



Child Death Review Guidelines 2005



September 27, 2005

**CHILD DEATH REVIEW PROGRAM
POLICY AND PROCEDURE GUIDELINES
TECHNICAL ASSISTANCE WORK GROUP**

Original Guideline Development:

| | |
|------------------|--|
| Melissa Allen | Child Death Review Coordinator Washington Department of Health |
| Carolyn Andersch | Child Fatalities Program Manager DSHS Children's Administration |
| Victoria Andrews | Executive Director SIDS Foundation of Washington |
| Judy Arnold | Coroner Thurston County Coroner |
| Lynda Benak | Forensic Nurse Specialist Snohomish County Medical Examiner's Office |
| Barbara Feyh | Director of Community and Family Services Spokane Regional Health District |
| Diane Gordon | Epidemiologist/Health Statistics and Assessment Manager Snohomish Health District |
| Deborah Icenogle | Pediatrician Spokane Child Death Review Team |
| Patti Powers | Deputy Prosecutor Yakima County |
| Martha Reed | Mason County Coroner President, WA Association of Coroners and Medical Examiners |
| Vicki Sussman | Child Death Review Data/Assessment Coordinator Washington Department of Health |

2005 Guidelines Update:

| | |
|--------------|--|
| Beth Siemon | Child Death Review Program Coordinator |
| Diane Pilkey | Child Death Review Data/Assessment Coordinator |

TABLE OF CONTENTS

| | | |
|---------|----|--|
| Chapter | 1 | Introduction and Historical Perspective |
| Chapter | 2 | Department of Health Responsibilities |
| Chapter | 3 | Local Team Membership and Responsibilities |
| Chapter | 4 | Child Death Review Process |
| Chapter | 5 | Access to Information and Confidentiality, HIPAA |
| Chapter | 6 | Data Collection |
| Chapter | 7 | Team Training |
| Chapter | 8 | Prevention and Community and Media Education |
| Chapter | 9 | Evaluation |
| Chapter | 10 | Ethics and the Influence of Bias |

Appendices

- A. Operating Principles for Child Death Review
- B. RCW 70.05.170 (1993) Child Mortality Review
- C. Related Washington Statutes
- D. DOH Early Notification of Childhood Death (ENCD) system
- E. Sample Forms:
 - a. Confidentiality Statement for Team Members
 - b. Records Request
 - c. Tracking Worksheet
- F. List of reports from DOH and local teams
- G. Effective Team Meetings
- H. CDR and HIPAA Fact Sheet
- I. Helpful Links
- J. Examples of Ethical Dilemmas
- K. ASTHO Issue Brief
- L. CDR- State of the Nation
- M. Glossary
- N. Washington Data Collection Form and Instructions

CHAPTER 1

INTRODUCTION AND HISTORICAL PERSPECTIVE

1.1 Washington State's Child Death Review system

Washington State's Child Death Review (CDR) process involves reviews of deaths of children aged birth through 17 years of age who have unexpectedly lost their lives. The death of a child is a great loss to family, friends and community and represents unfulfilled promises. A child's death is a sentinel event and can be a marker for the community of the health and safety of children. Understanding the circumstances surrounding a child's death is one way to make sense of the tragedy and may help to prevent other deaths of children. Child Death Review is a collaborative process that brings people together at a local level, from multiple disciplines, to share and discuss comprehensive information on the circumstances leading to the death of a child, and the response to that death. Reviews are conducted voluntarily at a county level by local health departments. The public health focus ensures that the team's role will be prevention, not investigation, and that the team's work will be confidential.

1.2 Overview of the Child Death Review Process

Child Death Review is a systematic comprehensive review of factors that contribute to deaths of children. The review is a coordinated, multi-disciplinary effort involving individuals from community agencies relevant to the health and welfare of children of all ages. A standardized process is used for the collection and review of information about the circumstances surrounding the death.

Child Death Review is intended to increase knowledge about the deaths of children, and in turn, lead to activities at the local and state level that will reduce the incidence of preventable childhood deaths. Child Death Review is not intended to review agency performance which is the responsibility of that agency's internal review process. See Appendix A for Operating Principles of a Child Death Review System.

1.3 History of the Washington System

Representatives from the Washington Department of Health (DOH) and the Department of Social and Health Services (DSHS) first met in 1990 to discuss potential Child Death Review activities and issues. At the same time, DSHS Children's Administration began convening its own community committees specifically to review deaths of children receiving that agency's services.

Over the next seven years, both agencies worked to bring a comprehensive Child Death Review system to Washington State. In 1993 local health jurisdictions were authorized by statute to conduct confidential child mortality reviews on a voluntary basis (RCW 70.05.170). A few jurisdictions began conducting reviews but the statewide system did not begin until the passage of a 1997 Governor's Budget proviso that provided funding for the work through the DOH.

This Governor's Initiative provided the impetus for an integrated statewide Child Death Review program. In July 1998, DOH began contracting with local health agencies to develop community Child Death Review Teams and conduct community reviews. At the same time, DOH and DSHS joined forces to develop a unified community Child Death Review process that would meet the mandates of both agencies.

The Washington State standard was to conduct reviews of every unexpected death of a Washington child under age 18. Funding for the DOH Child Death Review Program was provided by DOH under the auspices of the State of Washington. The total program amount was \$1 million per biennium. Two thirds of the funds were allocated to local health jurisdictions using a funding formula based on child death data for that jurisdiction. The remainder was allocated for state administration of the program, including data collection/analysis, technical assistance, training, and oversight.

As of July 2003 the state funds were eliminated. Some local teams continue the work and DOH continues to provide limited technical assistance and coordinate data collection and analysis.

1.4 How to Use these Guidelines

These guidelines are to be used as a reference and an informational resource for local Child Death Review teams as they create policies for the development, implementation and management of their local Child Death Review activities. We recommend that every team have written policies that specify the procedures for:

- Membership
- Jurisdiction
- Screening criteria and screening process
- Review process
- Team decision-making
- Confidentiality, access, and sharing of information within each team, with other Child Death Review teams in Washington State and with the DOH Child Death Review Program.
- Data collection
- Briefing/debriefing guests

1.5 Questions About the Guidelines

Suggestions or questions about these Guidelines should be directed to:

Beth Siemon
Child Death Review Coordinator
Washington Department of Health
PO Box 47880
Olympia, WA. 98504-7880

360-236-3516
FAX: 360-586-7868
beth.siemon@doh.wa.gov

OR

Diane Pilkey
Child Death Review Assessment Coordinator
Washington Department of Health
PO Box 47835
Olympia, WA 98504-7835

(360) 236-3526
FAX: (360) 236-2323
diane.pilkey@doh.wa.gov

CHAPTER 2

DEPARTMENT OF HEALTH RESPONSIBILITIES

2.1 Introduction

The CDR process begins with community based reviews of child deaths and data collection about the circumstances behind those deaths. Until July 2003, the Washington State Department of Health was responsible for the financial support, development and maintenance of a statewide Child Death Review system. Current financial support of local CDR teams occurs at the local level.

Specific DOH responsibilities are to help develop standard aggregate data elements, collect and analyze local Child Death Review data, and provide limited technical assistance to continuing local Child Death Review teams. The goal of the work is to use information gained from Child Death Reviews to develop strategies that will, in turn, reduce the incidence of preventable child deaths in Washington State.

2.2 DOH/DSHS Collaboration

Both DOH and DSHS have interest and authority to review the deaths of children. Under RCW 70.05.170 (Child Mortality Review) local health departments have the authority to examine factors that contribute to deaths of children less than 18 years of age. Information from such reviews is not subject to discovery in any administrative, civil, or criminal proceeding related to the death of a child reviewed. Also, members of the review committee cannot be subpoenaed to testify in such proceedings. (See Appendix B for RCW)

Under the Federal Child Abuse Prevention and Treatment Act (CAPTA), HB 1035 (1995) and RCW 74.13.640, DSHS Children's Administration reviews the deaths of children who are receiving services or have received services within the last 12 months or in a licensed facility. DSHS regional child fatality review teams have been in operation since 1994. Because of their interest in preventing deaths of children, DSHS has promoted having a CPS worker as a member of each local CDR team, participating in all reviews, not just those with DSHS involvement.

2.3 Technical Assistance and Training

DOH recognizes the importance of consistency and accuracy in the review process. Without this consistency, information collected about the reasons for childhood deaths may not be reliable or accurate. To this end, local CDR teams may request technical assistance directly from the Child Death Review staff at DOH.

Technical assistance and training on the CDR process is the responsibility of the Child Death Review program coordinator who works in the Child and Adolescent Health section of the DOH

Division of Community and Family Health. Duties in addition to technical assistance and training to local Child Death Review teams include program planning and implementation, and communication with team coordinators, other state agencies, the public, and the legislature.

2.5 Data Collection and Review

Despite the significant amounts of information on decedents and the causes of death available from mortality data, it is important to note that the circumstances surrounding many deaths are less well known. Detailed reviews of cases are often necessary to shed light on the nature of those circumstances and to identify ways to prevent similar deaths from occurring in the future.

Local Child Death Review teams, using a consistent and systemic process, collect comprehensive information which, in turn, provides the foundation for improved policies regarding access to health care, parenting, education, and the promotion of health of infants, children, and adolescents.

Information on the circumstances of a child's unexpected death is collected using a standardized data form (See Appendix N for CDR data form and instructions). Both local health jurisdictions and DOH have created reports using data aggregated from local Child Death Reviews.

The Child Death Review data coordinator position is in the Maternal Child Health Assessment section of the Department of Health's Division of Community and Family Health. This position is responsible for development and maintenance of the Child Death Review data collection and analysis system. Duties include maintaining a data tool that will be used by local teams to collect information about each child death reviewed, and providing technical assistance to local teams in the data collection process and analysis of data.

2.6 Prevention of Childhood Deaths

Every Child Death Review has the potential to yield information about preventable circumstances. Communities can use this knowledge to guide local prevention activities.

The statewide data collection system provides aggregate information about the nature and circumstances of childhood deaths in Washington. DOH reviews and analyzes this information in order to identify needed improvements in areas such as child health policy, child protection, and family services.

CHAPTER 3

LOCAL TEAM MEMBERSHIP AND RESPONSIBILITIES

3.1 Introduction

This chapter describes the composition of Child Death Review Teams and the roles and responsibilities of Child Death Review Team members. Local review Teams are the cornerstone of the Child Death Review process.

3.2 Membership

Child Death Review Teams should have multi-disciplinary, multi-agency and community-based representation. Teams may find it useful to have a Letter of Agreement with participating agencies that specifies the purpose of the team, team composition, time commitment, and replacement of the agency representative as needed.

Local teams should be composed of any of the people/agencies who may be involved in a death. Depending on the nature of the death, the age of the child and the particular expertise needed, participants may vary. For example, reviews of deaths of Native American children should include a representative from the tribe; review of a military dependent death should include a representative from the military community; review of SIDS deaths should include someone with expertise about SIDS. The Team will be composed of regular members who are almost always involved in every death as well as additional ad hoc members as needed.

Regular Team Members

Child Protective Services
Emergency Medical Services
Law Enforcement
Medical Examiner/ Coroner
Mental Health/Social Services
Pediatrician/Family Practitioner
Prosecutor
Public Health

Additional Team Members

Faith Community
Fire Review/Prevention
Forensic Pathology
Court Appointed Special Advocates (CASA)
Military Organizations
Other Health Care Providers
Traffic Safety/ State Patrol
Trauma Care
Tribes
Schools
Content experts (Domestic Violence,
Juvenile Justice, Sexual Assault, Disability,
Genetics, SAFE Kids, Substance Abuse,
Consumer Product Safety Commission)

3.3 Roles and Responsibilities

Multi-disciplinary reviews require the regular attendance and active participation of team members. Members may participate as community members or as representatives of their agencies. Team members must abide by team confidentiality standards.

The role of each Team member is to provide specialized knowledge and experience. The responsibility of each Team member is to participate in the inter-disciplinary review process, act as liaison between the Team and the member's agency and/or professional peers, collaborate in identifying prevention issues, and abide by standards/procedures guiding the Team's practice.

In Washington State, local health departments are the lead agency that coordinates the community Child Death Review Team. The designated Chair or Team Coordinator has the additional responsibility to:

- Determine meeting dates and send meeting notices to Team members.
- Obtain names and compile the summary sheet of child deaths to be reviewed, and distribute to team members two to three weeks prior to each meeting.
- Ensure that notices of child deaths are available for Team review.
- Ensure that new members receive a Team manual and an orientation to the CDR Team and process prior to their first meeting.
- Ensure that all new CDR team members and ad hoc members sign a confidentiality agreement.
- Encourage the sharing of information for effective case reviews.
- Chair the Team meetings and facilitate discussions.
- Complete and submit data reports to the State Child Death Review Program Office as directed.
- Ensure that the CDR Team operates according to protocols as defined by the Team or law.
- Promote CDR Team success in following through with recommendations and prevention initiatives/activities.
- Facilitate contacts with the media or designate a Team member as contact.
- Maintain contact with the Washington State Department of Health as needed.

The role of each specific Team member (in alphabetical order) includes:

Child Protective Services (CPS) has the legal authority and responsibility to investigate suspected abuse or neglect related child deaths and to provide protection to siblings and other family members who might be at risk. CPS team members can provide detailed information on families and on their reviews of child deaths. CPS may have prior agency contact information including reports of neglect or abuse and services previously or currently provided to a family. They are also a liaison to the broader child welfare agency and are knowledgeable about many community resources. Their knowledge on issues related to child abuse and neglect cases is essential to team effectiveness.

Consumer Product Safety Commission (CPSC) investigators may follow-up on deaths where a non-transportation consumer product (ex: bunk bed, space heater, infant carrier) was involved. Investigation may involve a telephone contact with family members or an on-site investigation. Information about the product, the child, and the sequence of events is collected. Important information included in CPSC investigation reports may contain the role of the product in the death, past CPSC actions or recalls of the product, and similar incidences known to CPSC.

Coroner/Medical Examiner presents basic information about cause and manner of death for children who die under suspicious, unexplained or unexpected circumstances, including findings from the scene review, autopsy and medical history. State law requires that all unexpected child deaths be reported to and investigated by a county medical examiner, coroner or prosecutor-coroner. A coroner is usually an elected official who is not required to be a physician or have specialized training in forensics. A medical examiner is a physician who is also either a board certified forensic pathologist, a qualified physician who is eligible to take the certification exam within one year, or who is specializing in pathology and will complete the exam within three years of the appointment (RCW 36.24.190).

Emergency Medical Services (EMS) is frequently first at the scene and observes critical information regarding the scene and circumstances of a child death, including the behavior of witnesses. EMS has well established relationships with other emergency services and can add a perspective on the broader issues of emergency response.

The **Faith Community** will be a resource for reviews in which the deceased child/family's religious beliefs and practices are key to the circumstances surrounding the death. In such situations, the team should consider including someone who has particular knowledge/understanding about those beliefs.

Fire Services is frequently first at the scene of a fire and observes critical information regarding the scene and circumstances of a child death, including the behavior of witnesses. As investigators, they have particular expertise about the cause of fires and community prevention efforts.

Forensic Pathology is a specialized medical field with knowledge of both disease and injury, mechanisms of sudden death and subtle forms of homicide. For reviews in which interpretation of autopsy findings is key to understanding the circumstances of the death, a forensic pathologist is highly recommended. Medical Examiners are physicians who are board certified in forensic pathology or who are eligible to take the certification exam within one year of appointment. Smaller counties with populations of less than two hundred fifty thousand generally have coroners who are elected or appointed to this office. These counties contract for forensic pathology services. Counties with populations of two hundred fifty thousand or more may adopt a system under which a medical examiner may be appointed to replace the office of the coroner.

Law Enforcement team members have training and experience in investigating the deaths of children. Law enforcement team members serve as liaisons between the team and other local law enforcement agencies. Their expertise in scene review and interrogation is essential to the

team.

Mental Health/Social Services representatives provide information and insight regarding the psychological issues related to events that caused a child death. Under some circumstances they can also provide information on a family's history of mental health treatment, assess the family's current need for services, provide information on grief counseling for the family or Team members and assist Team members in debriefing a death.

Military Organizations provide employment, medical care, law enforcement and social services for their community (members of the military and their dependents residing both on and off base). Military bases are located throughout the state of Washington and are a part of the larger community. Representatives of the military provide information about family circumstances, services received or available, and an understanding of the military culture.

Pediatrician/Family Practitioner/Other Healthcare Provider team members have expertise in health/medical matters concerning children. They can interpret medical records from hospitals and other medical providers. It is preferable to have medical experts who are experienced in treating victims of child abuse and neglect.

Prosecutors are responsible for prosecuting the deaths of children when a criminal act is involved. They provide information on criminal law and criminal and civil actions taken against those involved in the child deaths reviewed. They can also explain the status of a case and provide information about previous criminal prosecutions of family members or suspects in child deaths.

Public Health team members can provide vital records and information on county public health services. They can provide case histories and previous interventions concerning children who received services from public health. Public health agencies are often able to provide staff expertise in certain areas, such as SIDS.

School Counselors can provide perspective on a pertinent educational history of a child or a child's siblings. Information is generally communicated verbally because of restrictions in releasing school records. They also are knowledgeable about support services and interventions available within the school system and may provide leadership in implementing review team prevention recommendations.

State Patrol/Traffic Safety expertise is critical when a team is reviewing a child traffic death. In Washington, State Patrol investigates many traffic accidents, collects data on all traffic fatalities and appoints traffic safety specialists to initiate traffic safety activities in local communities.

Trauma Care hospital staff can provide pertinent information about a child who was transported to that facility as well as expertise on the trauma care system in general. They can also be useful in accessing records, and educating first responders on medical issues and hospital practices.

Tribal Representatives provide information about a particular family's circumstances and services received or available. They also bring expertise on Native American culture and Tribal governments. Tribes provide medical care, law enforcement and social services for their community (tribal members residing both on and off tribal lands). There are numerous Native American tribal governments in Washington State.

Content Experts can be invited to a review when specific expertise is needed to help the team review the death and/ or develop evidence-based prevention strategies.. Examples include persons with expertise in drowning prevention, domestic violence or sexual assault, product safety, genetics.

CHAPTER 4

CHILD DEATH REVIEW PROCESS

4.1 Introduction

Local Child Death Review coordinators should be aware of all deaths of children who are residents of the county or region over which the team has jurisdiction. The local health jurisdiction can maintain a record of such deaths in order that all can be screened for referral to the Child Death Review Team. The Team should meet as needed to review all cases. Even if there are no deaths to review, the Team should meet at least annually to review community child safety and injury prevention issues, team membership and policies/procedures.

4.2 Authorization for Child Death Reviews

RCW 70.05.170 authorizes local health departments to conduct child death reviews so that “preventable causes of child mortality” can be identified and addressed. To protect the process, the RCW provides protection of the review process from subpoena or discovery.

RCW 26.44.030 (7) authorizes DSHS to “conduct ongoing case planning and consultation with those persons or agencies required to report under this section, with consultants designated by DSHS and with designated representatives of Washington Indian tribes if the client information exchanged is pertinent to cases currently receiving child welfare services.”

RCW 74.13.640 authorizes DSHS to “conduct child fatality reviews in the event of an unexpected death of a minor in the state who is in the care of or receiving services from the department.” DSHS generates a report for the legislature upon completion of the review which is available to the public.

RCW 68.50.010 specifies the circumstances under which a county coroner has jurisdiction over bodies of deceased persons.

RCW 68.50.105 provides for coroner/Medical Examiner release of reports and records of autopsies or post-mortems to public health. (See Appendix C for related Washington statutes)

4.3 Scope and Jurisdiction of Local Child Death Team Reviews

The Washington Department of Health standard is that all unexpected deaths of children from age birth through age 17 who are residents of a county will be reviewed by that county's Child Death Review Team. Unexpected child deaths are those that do not result from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated (natural death) unless the illness or condition is the result of an injury, whether intentional or not. Examples of unexpected deaths include:

- Deaths whether there is evidence of or grounds for suspicion of maltreatment
- Sudden and unexplained deaths
- Deaths of indeterminate cause
- Unintentional (accidental) injury, including traffic deaths
- Intentional deaths (homicide, suicide)

In most cases deaths should be reviewed in the county of residence. In some circumstances, that Team may recommend that the death also be reviewed by the Team in the county where the fatal injury or death occurred.

Teams may determine, at their discretion, to review additional deaths, e.g. all child deaths in their county or region, regardless of whether they were unexpected or expected. Counties may elect to designate a medical subcommittee to review expected deaths for potential prevention components, and recommend a full review by the Team.

4.4 Timing of the Review

Ideally, reviews should be completed within six months of a child's death.

There are two major types of reviews: retrospective or periodic reviews and immediate reviews.

Retrospective CDR Reviews usually take place after completion of most, if not all of the investigation and information gathering. In certain unique circumstances, the team may decide to postpone the review until the criminal prosecution is completed. This is the most frequently used method of review and is used primarily to influence system and procedural changes for future investigations and service delivery, as well as to identify risk factors that can lead to prevention initiatives. The usual interval between a death and initiation of a review is three to six months unless information is unavailable due to a member agency's on-going investigation. The scope of CDR in Washington is retrospective reviews.

Immediate Response Reviews typically occur within 24 to 48 hours of a specific death. The Team is able to discuss case information immediately, thereby affecting the processes and procedures used during the active investigation of a child death. While this is rarely used by Washington State Teams and is not a requirement, teams do have the option of using this type of review in select cases.

Cases may need to be discussed at more than one meeting for several reasons. For example, the information is incomplete at time of the first review; members may wish to obtain additional

information from their agencies; a team member with significant information is absent or; the case information needs to be updated.

4.5 Screening and Information Gathering

Each team should define a screening process that addresses the following:

- Types of deaths to be reviewed.
- Timing of a review in relation to investigation and prosecution activities.
- Access to data from the DOH Center for Health Statistics' "Early Notification of Child Death (ENCD)" system which enables county registrars to identify local child deaths, both by occurrence and by residence.¹
- Screening of all child death certificates to determine appropriateness for team review.
- Circumstances under which additional records will be reviewed prior to a decision about appropriateness for team review.
- Criteria used when making decisions as to which sources of case information or history are relevant to the review.
- Gathering necessary information for review.
- Handling of records needed for the Child Death Review.

Sources of information for a Child Death Review can include:

- Early Notification of Childhood Death (ENCD) system (See Appendix D for information on the ENCD system)
- Birth certificate
- Death certificate
- Death scene review report
- Law enforcement investigation reports (e.g. State Patrol, sheriff, city police)
- Prosecuting Attorney's reports
- Coroner and medical examiner reports
- Autopsy report
- Emergency Medical Services report
- Fire investigation reports
- Mental health and drug treatment reports
- Child Protective Services (CPS) and other DSHS records, reports, or abstracts
- Public Health Records
- School records, school counselor report
- Medical and hospital records
- Military or tribal reports
- Other related deaths

¹ For more information about the ENCD system or to inquire about getting access to the system, please contact Phyllis Reed at the Washington State Department of Health, Center for Health Statistics (TEL: 360-236-4324; Email: Phyllis.reed@doh.wa.gov).

4.6 Meeting Attendance and Confidentiality

Team meetings are confidential and are to be attended only by team members and invited guests. The team will invite other professionals as necessary, particularly to insure the cultural appropriateness of the process. Media and family members are not part of the review team.

Everyone in attendance at a child death review should sign a prepared confidentiality statement in which the signer agrees not to divulge information discussed at the review meeting. See sample Confidentiality Statement in Appendix E.

Each profession brings to the team its perspective, professional expertise and commitment to the interdisciplinary process. An effective review process requires the regular attendance and active participation of team members. For each review, the minimum expertise needed should be identified and the review should not proceed unless those members are present.

4.7 Meeting Process

Each team should develop a format for conducting a review that supports an orderly, succinct presentation of case information, full participation of all members and a means of reaching conclusions as to the prevention issues raised by the review. Identifying prevention factors requires a detailed review of circumstances behind the death, beyond manner and cause.

The amount of time required for completion of each review will vary. Each member presents applicable information. Identifying all information needed is essential. There may be times in which certain information is not available to the review. Incomplete data regarding the circumstances of a death focuses attention on potential gaps. Such awareness allows the team to address these issues through its members, team reports and prevention efforts. It is important to note that on the data collection form so that statewide concerns can be identified.

Conclusions are reached only after all information is reviewed. The team should use agreed upon methods for arriving at conclusions and recommendations. Consensus-building and voting are two such methods. The team review is a professional process in which members may express concerns or disagreements about specific cases. However, reviews are designed to look at system issues and not the performance of individuals. Teams should not serve as peer reviews. Should disagreements among members disrupts the review process, the team coordinator should intervene to allow the review to continue.

4.8 Core Information Needed to Conduct a Review

At a minimum, the following types of information may be needed to conduct a comprehensive review:

- Death certificate
- Death investigation reports, including, scene reports, interviews, information on prior criminal activity

- Autopsy reports
- Medical and health information concerning the child, including birth records and health histories
- Information on the social services provided to the family or child, including WIC, Family Planning and Child Protective Services
- Information from court proceedings or other legal matters resulting from the death
- Relevant family information, including siblings, biological and stepparents, extended family, living conditions, neighborhood, prior child deaths, etc.
- Relevant information on the child's educational experiences

At each case review, members should seek to answer:

1. Is the information needed complete or should we recommend further information gathering? If so, what more do we need to know?
2. What recommendations do we have to improve our information gathering?
3. Are there services we should provide to family members, other children and other persons in the community as a result of this death? What services are lacking in our community?
4. Could this type of death have been prevented and if so, what risk factors are involved in these types of child deaths?
5. What changes in behaviors, technologies, agency systems and/or laws could minimize these risk factors and prevent another death?
6. What are our best recommendations for helping to make these changes?
7. Who should take the lead in implementing our recommendations?
8. Do we need to discuss this case at our next meeting?

4.9 Records Management

There are two approaches to obtaining information needed for a review:

- The record may be reviewed at its original site by the appropriate team member and then abstracted or summarized verbally at the team meeting. No copies of records are made for team members.
- A copy of the needed record may be requested by the Child Death Review team coordinator or other designated person and then summarized or copied for distribution at the team meeting. If copies of confidential written materials are distributed to members at the meeting, they should be collected and shredded at the conclusion of the review. Any records obtained for Child Death Review must be protected. Because of the sensitive nature of such records, we advise that they be kept in a locked location.

At the review, information on the circumstances of a child's unexpected death is collected using a standardized data form. See Chapter 6 for further detail. Local health departments and the

Washington State Department of Health have compiled reports using data aggregated from local Child Death Reviews. See Appendix F.

No records with identifying case information, other than the data form, should be kept by local Child Death Review teams. A copy of the completed data form (electronic or hard copy) should be stored in a locked location. Data collected electronically should never be stored on a shared network environment unless access to those files is limited.

4.10 Effective Team Meetings²

Successful CDR is a complex and dynamic process and maintaining an effective CDR team requires creativity, dedication and perseverance. Changes over time will affect the functioning of your team and you should periodically address how the team is functioning. Key points for team members to understand:

- Team membership is a long term commitment
- Team membership fosters ongoing professional development
- A team is both a message to the community and a message from the community.

Effective review team meetings require team members to:

- Come prepared with information on the deaths to be reviewed.
- Share their information openly and honestly.
- Seek solutions instead of blame.

See Appendix G for Tips for Effective Reviews from Washington CDR teams.

The National MCH CDR Clearinghouse has put out “Guides for Effective Child Death Reviews,” which includes specific suggestions for reviewing different types of deaths. The guide is available at: <http://www.childdeathreview.org/reports/Guides.pdf>

4.11 Funding

Original funding to initiate the DOH Child Death Review Program was provided from 1999-2003 by DOH under the auspices of the State of Washington. Since July 2003, Washington’s local CDR teams are funded at the local level. Sources of funding include:

- MCH Block grant
- Preventive Health block grant
- Local capacity funds

Nationally, CDR has never been heavily funded and relies on volunteer efforts. As of fall 2004, the MCH Title V Block grant directly funded about 8 state programs and state general funds paid for 7 programs. Other programs get funding from multiple sources, including tobacco settlement dollars, county funds, Children’s Justice Funds, CDC Child Maltreatment grant, SIDS Foundations, state autopsy money, and a state death certificate fee.

² Source: A Program Manual for Child Death Review from the National MCH Center for Child Death Review

CHAPTER 5

ACCESS TO INFORMATION AND CONFIDENTIALITY

5.1 Introduction

Information and records are confidential throughout the Child Death Review process. This includes but is not limited to:

- Requests for and receipt of information for case reviews
- Use of information, documents and records to collect data for Child Death Reviews
- Storage of information and records related to a deceased child or the child's family
- Presentation of records, documents or information during case reviews
- Discussions during review of individual cases
- Access to the Child Death Review web-based reporting system

5.2 Access To Information

Under RCW 70.05.170, teams may request information and records regarding a deceased child as necessary to carry out the purpose and duties of the team. Such material is needed to assess circumstances of the death. This pertains to information from within as well as outside the team's jurisdiction.

A standing request for records and information may be developed by the team to facilitate the gathering of information required to conduct a death review. It should be addressed to the "custodian of the records" or the agency director and include the review team authorizing statute and information regarding the team operation and purpose. These requests are particularly useful for acquiring information from agencies that do not have a representative on the team. When reviewing deaths of children whose deaths occurred in a county other than the county of residence, team members should contact the agency which corresponds to theirs and request the pertinent information. See Appendix E.

5.3 Confidentiality of Child Death Review Team Records and Information

RCW 70.05.170 (1993) authorizes local health jurisdictions (LHJ's) to conduct child mortality reviews and provides confidentiality protections for the proceedings and the members of local health department Child Death Review teams. Discussions at a review team meeting are considered confidential and thus not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceedings. Note: This protection does not extend to records received from another source and used by the team in its review. Such records *may* be discoverable or subject to subpoena from the original source.

The RCW authorizes LHJ's to carry out child death reviews and does not specify the

jurisdictional limits of those reviews. The Department of Health interprets the statute to allow exchanges of confidential information between involved local health jurisdictions. Only in this way can the purpose of the authorizing statute be achieved.

The Child Death Review Team should use the required information and records only as necessary to carry out the team's statutory duties. Information and records are to be used and referred to ONLY in confidential meetings of the review team, and ONLY for the purpose of gathering information pertinent to that review.

A team member may not disclose any information that is confidential. Each member agrees to keep meeting discussions and information confidential. This is essential for each agency to be able to fully participate in the meetings. Procedures should ensure that all new members and invited guests new to that meeting sign a confidentiality agreement prior to the beginning of that meeting. It may be helpful to have a confidentiality reminder as part of the regular sign-in process.

5.4 Protecting Family Privacy

No member of the Child Death Review Team shall contact, interview, or obtain information by request or subpoena from a member of the deceased child's family, unless that is required by that member's other official duties as an officer or employee of an agency.

Information obtained and results of child fatality reviews may be disclosed by DOH or Child Death Review team members only in summary, statistical, or other form that does not identify the deceased child or family.

5.5 CDR and HIPAA

Child Death Review (CDR) is a public health program administered through local health jurisdiction-based review teams. RCW 70.05.170 authorizes teams based in local health jurisdictions to perform CDR and provides for the publication of statistical compilations and reports related to the team's review so long as the summaries or reports do not identify the individual cases or sources of information. Disclosures to CDR teams that are acting under the auspices of a public health agency are permissible under HIPAA. (See Appendix H for CDR HIPAA Fact Sheet)

CHAPTER 6

DATA COLLECTION

6.1 Introduction

A key component of the statewide Child Death Review program is the collection of standardized data at both the state and local level. In order to facilitate this process, DOH in collaboration with local team members and experts in the field created a data collection instrument that local Child Death Review teams complete during the process of conducting their reviews. Use of this data collection instrument allows capture of consistent information statewide and analysis of these data can be used to generate data-driven recommendations for the reduction of preventable childhood deaths.

The Department of Health collects confidential (identifiable) data from local health jurisdictions and aggregates it at the state level in order to inform program planning and policy. Confidentiality requirements are followed and any data disseminated by the Department of Health is such that no family or child will be identified.

Data from the review can be entered into a web-based reporting system supported by the Department of Health. Teams can also submit hard copies to the DOH Assessment Coordinator for entry into the web-based reporting system. We suggest that the most accurate method of documenting information gleaned from the review is to complete the data form (electronic or paper) at the time of review. Completing the data tool with the team is a way of assuring that all aspects of the review have been covered. For detailed data collection instructions, please see the Child Death Review Data Collection Form (Appendix N). For more information on the CDR web reporting system, see: http://www.doh.wa.gov/cfh/CDR/cdr_tableofContents.htm

6.2 Technical Assistance

DOH will provide ongoing staff support and technical assistance for data collection and digital certificates to approved individuals in local health jurisdictions access to web-based reporting system. Please feel free to e-mail or call with your data collection and Child Death Review web-based reporting system questions.

6.3 Data Security

DOH's responsibility regarding confidentiality of data is governed by Department of Health Policy No. 17.005, "Employee Responsibilities with Confidential Information." In part, this policy reads:

Access to identifiable and confidential data/information will be limited to DOH staff and others who are authorized to use the data/information to achieve the

authorized purposes of a DOH project or program. Use by other personnel or for other purposes (e.g., research) will require written approval from the division's Assistant Secretary, or designee per DOH Policy/Procedures 02.001, and will only be granted in accordance with law.

CDR data can be submitted to the state either via hard copies or entered directly into the web-based reporting system. Only authorized representatives of the DOH Child Death Review Program staff can enter data into the DOH Child Death Review Web-based Reporting System. These personnel include the Child Death Review Program Coordinator, the Child Death Review Data/Assessment Coordinator, and designated support staff. Each local Child Death Review team should select persons authorized to enter data into their web-based system and limit access to these persons accordingly. Each person with access to the database should sign an acknowledgement of your confidentiality policy.

Access to the CDR web-based reporting system is only available through Transact Washington via the use of a digital certificate. Users of the system obtain a digital certificate from Digital Signature Trust (DST) for a fee (paid by DOH), by providing the necessary proofs of identification to DST. Once the user has received their digital certificate, they request access to the application and access is granted from the DOH to appropriate personnel. Please contact the CDR Assessment Coordinator for more information.

For those using the paper version of the Child Death Review Data Collection Form, ensure that only authorized persons have access to these forms, and that the forms are stored in a secure, locked location, along with any other confidential information related to the review.

CHAPTER 7 TEAM TRAINING

7.1 Introduction

Orientation and ongoing training of review teams is necessary to maintain consistency in application of review methods and collection activities. A primary goal of such training is to develop consistent, accurate, and thorough review processes. This will help ensure meaningful information that will lead to prevention strategies for reduction of childhood deaths.

7.2 Orientation

The team should provide an orientation to every new member prior to the member's participation in the review process. The orientation should include at a minimum, the following topics:

- Process and goals of Child Death Review
- Legislative intent
- Responsibilities and limitations of team membership
- Importance of regular attendance and participation of team members.
- Confidentiality
- Public access to team information
- Promotion of culturally competent approaches in case review
- Use of the data collection tool.

7.3 In-Service

An integral part of every review team's operation is to keep members informed of team related training, changes in laws regarding their profession, and new child death or injury prevention programs. Periodically scheduling presentations and providing informative handouts will enhance the team's ability to accomplish its objectives.

7.4 Training and Technical Assistance from DOH

DOH recognizes the importance of consistency and accuracy in the information provided to team members. To this end, DOH Child Death Review Program will provide technical assistance at the request of the local Team coordinator. DOH will also share through a listserv any training or funding opportunities that become available.

CHAPTER 8

PREVENTION AND COMMUNITY EDUCATION

8.1 Introduction

Information obtained from the statewide Child Death Review data collection system is critical to identifying the nature and cause of childhood deaths in Washington State.

DOH and local Child Death Review teams review and analyze information on the nature of preventable childhood deaths in Washington. Local teams identify trends in child death statistics for their own communities, and develop and implement community education and prevention plans. Some local CDR teams in Washington have moved from data collection to recommending and implementing prevention and system improvements. This includes educating the community and working with the media.

8.2 Local Community Prevention

Each local community should consider the recommendations from the local team. In some communities, the review team itself may choose to take the initiative to act on recommendations. Other communities may decide that recommendations for action should go to other groups such as ad-hoc community action teams. The composition of the group is best left to the discretion of the local community, but it is crucial that action teams include high-level decision makers with the ability to make choices, prioritize actions, and facilitate the implementation of recommendations.

8.3 State Prevention Activities

Data from reviews has been aggregated and analyzed by DOH. These data have been used in multiple reports (Appendix F). State agencies and community groups have used CDR data to educate, develop policy and design and implement statewide prevention strategies aimed at the reduction of child fatalities.

8.4 Working with the Media³

The work of CDR often involves sensitive issues and high profile cases, many of which are of great interest to the public and to the media. Teams also provide recommendations on prevention strategies and engage in prevention programs that require public awareness and the attention of the media. At the same time, Teams work under strict confidentiality constraints of

³ Source: A Program Manual for Child Death Review from the National MCH Center for Child Death Review

law and policy that can make it difficult to respond appropriately to the media. Information should never be released to the media in a way that can identify a particular death.

8.5 The Need for a Media Strategy

Having a media strategy in place for how to respond to media requests will help the Team be clear about how media requests are handled. A media strategy not only protects information that cannot become part of the public domain, and, at the same time, permits interaction with the press in a way that helps the Team achieve its goals.

A good media strategy has three components:

1. A policy of how a team interacts with the media
2. A proactive media relations plan that addresses public education and prevention campaigns
3. A media management protocol

A media strategy will help a Team:

- Generate positive publicity
- Gain the support of governmental agencies and the general public for its work and goals

8.6 Guiding Principles for Developing a Media Strategy

A written strategy lends consistency to a Team's protocols and establishes a procedural order. Some of the principles that might guide development of a media strategy include:

- Preventing child deaths is a primary goal for the CDR Team, but it is also a responsibility of the entire community.
- The review Team supports the public's right to know what it does generally.
- Confidentiality concerns are important to protect the exchange of information among Team members and with the professional community, encourage open participation and keep matters private which are not public business.
- The Team will always answer the media's questions honestly, including, as appropriate, telling the media when it cannot answer questions. Deception, pretension and omission hinder good media relationships.
- When speaking on behalf of the Team, one Team member should be designated as the spokesperson for the media. This member should be knowledgeable and articulate. The Team coordinator is a likely choice. Alternatively, the Team can consider using the public information officer at one of its member agencies.
- All Team members are aware of the Team's confidentiality policies and statutory mandates establishing them, even if they are unlikely to speak with the media.
- The Team needs a cooperative media and supportive general public to reach its goals.
- The media policy should be written with the participation of all Team members.
- The media policy should be distributed to all Team members.

CHAPTER 9 EVALUATION

Evaluation is an essential component of prevention and surveillance programs such as CDR. Evaluation should be built into the process and is based on the goals and objectives of the program. Some of the questions posed by evaluation of such a program include:

- How do we know if we are meeting our goals and objectives?
- How effectively is the team functioning?
- What is (are) the effect (s) of the CDR on policy and procedure?

Components of Evaluation

Process Evaluation: A process Evaluation examines how the team works, its components and if the team is functioning effectively. If an objective of the program is to improve communication and cooperation among agencies and disciplines, then some example evaluation questions to address could include:

- Are all of the deaths that should be reviewed being reviewed in a timely manner?
- Does the team have appropriate representation at the reviews?
- Do team members bring the necessary information to the reviews?
- Is the meeting being run effectively?
- Is there an atmosphere of trust?
- What is the quality of the data collected?
- Does your team have procedures that ensure confidentiality?

Intermediate Evaluation: This aspect of evaluation can focus on tracking the progress of recommendations coming from the review process.

- Is the CDR team making recommendations that are evidence-based?
- Are the recommendations being used? If not, why not?
- Were any changes made (in programs, legislation etc.) as a result of the CDR process?

Outcome Evaluation: Outcome evaluation focuses on whether teams are having an impact on child deaths. It is difficult if not impossible to determine if the CDR process had a direct impact on child death rates because CDR focuses on identifying risk factors, system and services failures and prevention strategies as well as improving agency communication and cooperation and may not be measurable in terms of health outcomes. It is therefore difficult to link direct recommendations to a change in the rate of child deaths.

Evaluation Methods:

Based on available resources for conducting an evaluation of the CDR process, an evaluation can be as simple as an anonymous survey of team members or a combination of the methods listed below. Some methods to evaluate the program include:

- Documentation or review of written records
- Observation
- Surveys
- Interviews
- Focus Groups

For assistance with evaluation, feel free to contact the DOH. For more information on evaluation, see Appendix I.

CHAPTER 10

ETHICS AND THE INFLUENCE OF BIAS⁴

10.1 Ethical Dilemmas

“Ethics” is commonly defined as a set of moral principles or a system of moral values that govern an individual or group. It involves both the acts of omission (failure to do something) and commission (doing something you should not). The CDR process explores many aspects of a death through an interdisciplinary process and through multiple dimensions. Some of the areas the review may impact include:

- Professional practice
- Agency mission and function
- Team membership and participation
- Community obligation and commitment
- Personal, familial, spiritual or faith-based values

A conflict between or among any of these dimensions adds to the complexity of the review and may lead to ethical dilemmas among the Team members. Many of the professions represented by the Team have established written standards of practice reflected in a Code of Ethics. However, the language of the standards may be open to individual interpretation.

The work of CDR Teams substantively influences social policy which affects communities in varied and, sometimes, unanticipated ways. Because social policy has such a broad influence, it is imperative that the Team work reflect thoughtful and ethical professional practice.

Sometimes the relationship between ethics and what the law requires may not be the same, or may not be clearly distinguished. While closely related, ethical responsibilities usually exceed legal duties. In some cases, legal duties may not necessarily be ethical. Sharing of information is often the first ethical dilemma that emerges for Team members. Some examples of ethical dilemmas Teams may face are identified in Appendix J.

10.2 Decision-Making and the Influence of Bias

“Bias” refers to a partiality or prejudice that is not grounded in substantiated information. Bias is what everyone brings to their work based on their own beliefs, life events and values. It affects how Team members process and interpret information, as well as how they perceive events based on past experiences. Often our first impression of a person or scene is the lasting impression, and we seek to confirm what is compatible with our belief system, and/or dismiss conflicting or contradictory elements that are not compatible.

⁴ Source: A Program Manual for Child Death Review from the National MCH Center for Child Death Review

What is important is just to recognize and acknowledge the bias every member brings to the Team. Bias can be minimized by:

- Seeking out experts for an objective evaluation and analysis of evidence.
- Looking at source documents rather than accepting hearsay.
- Be willing and open to change a position or belief based on evidence.
- Communicating openly and honestly with Team members to express concerns or a dissenting opinion.

Appendices

- A. Operating Principles for Child Death Review
- B. RCW 70.05.170 (1993) Child Mortality Review
- C. Related Washington Statutes
- D. DOH Early Notification of Childhood Death (ENCD) system
- E. Sample Forms:
 - a. Confidentiality Statement for Team Members
 - b. Records Request
 - c. Tracking Worksheet
- F. List of reports from DOH and local teams
- G. Effective Team Meetings
- H. CDR and HIPAA Fact Sheet
- I. Helpful Links
- J. Examples of Ethical Dilemmas
- K. ASTHO Issue Brief
- L. CDR- State of the Nation
- M. Glossary
- N. Washington Data Collection Form and Instructions

Appendix A: Operating Principles for Child Death Review

The following are taken from the Maternal and Child Health National CDR Clearinghouse manual and provide overarching principles of the child death review process. These can be adapted as needed by local Washington CDR teams.

Operating Principles of Child Death Review

- The death of a child is a community responsibility.
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- A death review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected.

Purpose of Child Death Review

Through a comprehensive, multidisciplinary and multi-agency review of child deaths, gain a better understanding of how and why children die and use the findings to take action to prevent other deaths and improve the health and safety of children in the community.

Selected Objectives of a Child Death Review Process

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every unexpected child death and establish a minimum data set on the causes of child deaths.
2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.
3. Improve agency responses in the investigation of child deaths
4. Improve delivery of services to children, families, providers and community members.
5. Identify specific barriers and system issues involved in the deaths of the children.
6. Identify significant risk factors and trends in child deaths.
7. Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.
8. Increase public awareness and advocacy for the issues that effect the health and safety of children.

Objective 1: Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every unexpected child death and establish a minimum data set on the causes of child deaths.

- Ensures Team members are informed of deaths and are able to take action in a timely manner

- More information may be collected if there is insufficient information to determine how a child died
- Reviews can lead to modifications of death certificates

Objective 2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.

- Meeting regularly can improve interagency cooperation and coordination
- The benefits of sharing information and clearly understanding agency responsibilities can make the CDR process worthwhile in and of itself.
- Reviews facilitate valuable cross-discipline learning and strategizing.
- Reviews improve interagency coordination beyond the review meetings.

Objective 3. Improve agency responses in the investigation of child deaths.

- Reviews promote timelier, more efficient notification of child deaths, facilitating more timely investigations.
- Sharing information on the type of investigation conducted leads to improved investigation standards.
- Reviews can identify ways to better conduct and coordinate investigations and resources.
- Many teams report that new policies and procedures for death investigation have resulted from reviews.

Objective 4. Improve delivery of services to children, families, providers and community members.

- Reviews can identify the need for delivery of services to families and other in a community following a child death.
- Reviews can facilitate interagency notification protocols to ensure service delivery.

Objective 5. Identify specific barriers and system issues involved in the deaths of children.

- Team members can help agencies identify improvements to policies and practices that may better protect children from harm.

Objective 6. Identify significant risk factors and trends in child deaths.

- With a broad, ecological perspective, medical, social, behavioral and environmental risks are identified and more easily addressed.

Objective 7. Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.

- Every review should conclude with a discussion and recommendations of how to prevent a similar death in the future.
- Reviews are intended to be a catalyst for community action.
- Teams are not expected to always take the lead, but should identify where and to whom to direct recommendations, then follow-up to ensure they are being implemented. Solutions can be short-term or long-term.

Objective 8. Increase public awareness and advocacy for the issues that affect the health and safety of children.

- When review findings on the risks involved in the deaths of children are presented to the public, opportunities can be identified for public education and advocacy.

Appendix B: Washington State's Child Death Review Legislation

RCW 70.05.170

Child mortality review.

(1)(a) The legislature finds that the mortality rate in Washington state among infants and children less than eighteen years of age is unacceptably high, and that such mortality may be preventable. The legislature further finds that, through the performance of child mortality reviews, preventable causes of child mortality can be identified and addressed, thereby reducing the infant and child mortality in Washington state.

(b) It is the intent of the legislature to encourage the performance of child death reviews by local health departments by providing necessary legal protections to the families of children whose deaths are studied, local health department officials and employees, and health care professionals participating in child mortality review committee activities.

(2) As used in this section, "child mortality review" means a process authorized by a local health department as such department is defined in [RCW 70.05.010](#) for examining factors that contribute to deaths of children less than eighteen years of age. The process may include a systematic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; analysis of individual case information; and review of this information by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.

(3) Local health departments are authorized to conduct child mortality reviews. In conducting such reviews, the following provisions shall apply:

(a) All medical records, reports, and statements procured by, furnished to, or maintained by a local health department pursuant to [chapter 70.02 RCW](#) for purposes of a child mortality review are confidential insofar as the identity of an individual child and his or her adoptive or natural parents is concerned. Such records may be used solely by local health departments for the purposes of the review. This section does not prevent a local health department from publishing statistical compilations and reports related to the child mortality review, if such compilations and reports do not identify individual cases and sources of information.

(b) Any records or documents supplied or maintained for the purposes of a child mortality review are not subject to discovery or subpoena in any administrative, civil, or criminal proceeding related to the death of a child reviewed. This provision shall not restrict or limit the discovery or subpoena from a health care provider of records or documents maintained by such health care provider in the ordinary course of business, whether or not such records or documents may have been supplied to a local health department pursuant to this section.

(c) Any summaries or analyses of records, documents, or records of interviews prepared exclusively for purposes of a child mortality review are not subject to discovery, subpoena, or

introduction into evidence in any administrative, civil, or criminal proceeding related to the death of a child reviewed.

(d) No local health department official or employee, and no members of technical committees established to perform case reviews of selected child deaths may be examined in any administrative, civil, or criminal proceeding as to the existence or contents of documents assembled, prepared, or maintained for purposes of a child mortality review.

(e) This section shall not be construed to prohibit or restrict any person from reporting suspected child abuse or neglect under [chapter 26.44 RCW](#) nor to limit access to or use of any records, documents, information, or testimony in any civil or criminal action arising out of any report made pursuant to [chapter 26.44 RCW](#).

[1993 c 41 § 1; 1992 c 179 § 1.]

Appendix C: WASHINGTON STATE STATUTES RELEVANT TO CHILD DEATH REVIEW

Updated 2005

| RCW | TITLE | CHAPTER | SECTION | RELEVANCE |
|-----------------|--|---|--|--|
| RCW 9A.32.055 | WASHINGTON CRIMINAL CODE | HOMICIDE | HOMICIDE BY ABUSE | Death by child abuse. It is a Class A felony. |
| RCW 10.97.050 | CRIMINAL PROCEDURE | WASHINGTON STATE CRIMINAL RECORDS PRIVACY ACT | CERTAIN INFORMATION AS RESTRICTED OR UNRESTRICTED—RECORDS | Criminal conviction records are public record. Specifies circumstances under which non-conviction data may be released. |
| RCW 13.50.050 | JUVENILE COURTS AND JUVENILE OFFENDERS | KEEPING AND RELEASE OF RECORDS BY JUVENILE JUSTICE OR CARE AGENCIES | RECORDS RELATING TO COMMISSION OF JUVENILE OFFENSES—RELEASE OF INFO TO SCHOOLS | Official court files are open to public unless “sealed.” All other records are confidential. Law enforcement and prosecuting attorneys may cooperate in releasing pertinent information to a school. |
| RCW 26.44.030 | DOMESTIC RELATIONS | ABUSE OF CHILDREN | REPORTS – DUTY & AUTHORITY TO MAKE—INTERVIEWS OF CHILDREN—DEPENDENCY HEARINGS | Mandatory reporting law. CPS is authorized to do case planning with service providers if in best interest of child. |
| RCW 26.44.031 | DOMESTIC RELATIONS | ABUSE OF CHILDREN | UNFOUNDED REFERRALS--REPORT RETENTION. | DSHS must destroy information on unfounded reports after 6 years unless another report is received within that period, |
| RCW 42.17.310 | PUBLIC OFFICERS AND AGENCIES | DISCLOSURE—CAMPAIGN FINANCES—LOBBYING—RECORDS | CERTAIN PERSONAL & OTHER RECORDS EXEMPT | Defines which public records are <u>exempt</u> from public inspection. |
| RCW 42.17.31902 | PUBLIC OFFICERS AND AGENCIES | DISCLOSURE—CAMPAIGN FINANCES—LOBBYING—RECORDS | INFANT MORTALITY REVIEW RECORDS | Identifiable records or documents obtained, prepared, or maintained by the local health department for purposes of infant mortality review may not be released to the public. |

| RCW | TITLE | CHAPTER | SECTION | RELEVANCE |
|----------------|--|---|---|--|
| RCW 43.20A.050 | STATE GOVERNMENT -- EXECUTIVE | DEPARTMENT OF SOCIAL AND HEALTH SERVICES | SECRETARY OF SOCIAL AND HEALTH SERVICES - POWERS AND DUTIES | Gives the secretary complete charge and supervisory powers over the internal affairs of the department except when specifically limited by law. |
| RCW 43.70.050 | STATE GOVERNMENT -- EXECUTIVE | DEPARTMENT OF HEALTH | COLLECTION, UTILIZATION, AND ACCESSIBILITY OF HEALTH-RELATED DATA | All state agencies that have access to population-based, health related data are directed to allow the secretary access to such data. If identifiable, this data shall not be disclosed, subject to disclosure, discoverable or admissible in judicial or administrative proceedings. |
| RCW 43.70.130 | STATE GOVERNMENT -- EXECUTIVE | DEPARTMENT OF HEALTH | POWERS AND DUTIES OF SECRETARY – GENERAL | DOH authorized to study causes of morbidity and mortality and report to the SBOH |
| RCW 43.103.100 | STATE GOVERNMENT -- EXECUTIVE | WASHINGTON STATE FORENSICINVESTIGATIONS COUNCIL (FIC) | SUDDEN INFANT DEATH SYNDROME – TRAINING-- PROTOCOLS | FIC develops and offers training on sudden, unexplained child death, including but not limited to SIDS - for first responders, coroners, medical examiners, prosecuting attorneys serving as coroners, investigators, and inclusion in state criminal justice training curriculum. Each county shall use a protocol endorsed by FIC to investigate sudden unexplained death of children and autopsies for children under 3 whose deaths are sudden and unexplained. |
| RCW 46.52.080 | MOTOR VEHICLES | ACCIDENTS – REPORTS – ABANDONED VEHICLES | CONFIDENTIALITY OF REPORTS – INFORMATION REQUIRED TO BE DISCLOSED – EVIDENCE | All accident reports are for confidential use of prosecutor, police/sheriff, licensing, WSP and other officer or commission as authorized by law. |
| RCW 68.50.010 | CEMETERIES, MORGUES, AND HUMAN REMAINS | HUMAN REMAINS | CORONER’S JURISDICTION OVER REMAINS | Specifies circumstance under which coroner takes jurisdiction of remains. |

| RCW | TITLE | CHAPTER | SECTION | RELEVANCE |
|---------------|--|--|--|--|
| RCW 68.50.104 | CEMETERIES, MORGUES, AND HUMAN REMAINS | HUMAN REMAINS | COST OF AUTOPSY | Partial reimbursement from the death investigations account to counties for autopsy costs. |
| RCW 68.50.105 | CEMETERIES, MORGUES, AND HUMAN REMAINS | HUMAN REMAINS | AUTOPSIES, POST MORTEM-- REPORTS AND RECORDS CONFIDENTIAL—EXCEPTIONS | Authorizes coroner to release reports & records of autopsies/post mortems to public health officials. |
| RCW 70.02.050 | PUBLIC HEALTH AND SAFETY | MEDICAL RECORDS – HEALTH CARE INFORMATION ACCESS & DISCLOSURE | DISCLOSURE WITHOUT PATIENT'S AUTHORIZATION | Authorizes hospital or health care provider to disclose, without the patient's authorization, limited health care information in cases where there is a need to know by by fire, police, sheriff, or other public authority |
| RCW 70.05.010 | PUBLIC HEALTH AND SAFETY | LOCAL HEALTH DEPARTMENTS, BOARDS, OFFICER—REGULATIONS | DEFINITIONS | Definitions of local health departments, local health officer, local boards of health and health districts. |
| RCW 70.05.170 | PUBLIC HEALTH AND SAFETY | LOCAL HEALTH DEPARTMENTS, BOARDS, OFFICERS – REGULATIONS | CHILD MORTALITY REVIEW | Authorizes local health depts to conduct child mortality reviews, including review of medical, clinical, and hospital records, analysis of this information by a team of professionals. All records and the outcome of reviews are confidential. |
| RCW 70.58.104 | PUBLIC HEALTH AND SAFETY | VITAL STATISTICS | REPRODUCTIONS OF VITAL RECORDS – DISCLOSURE OF INFORMATION FOR RESEARCH PURPOSES – FURNISHING OF BIRTH AND DEATH RECORDS BY LOCAL REGISTRARS. | Availability of birth and death records by state and local registrars. |
| RCW 71.05.390 | MENTAL ILLNESS | MENTAL ILLNESS - ADULTS | CONFIDENTIAL INFORMATION & RECORDS – DISCLOSURE | Specifies circumstances under which confidential mental health records may be disclosed. |

| RCW | TITLE | CHAPTER | SECTION | RELEVANCE |
|---------------|-------------------|-----------------------------------|---|--|
| RCW 71.34.210 | MENTAL ILLNESS | MENTAL HEALTH SERVICES FOR MINORS | COURT RECORDS AND FILES CONFIDENTIAL – AVAILABILITY | Specifies circumstances. May only be released to the minor, the minor's parents and the minor's attorney. The court may also release records to others if good cause is shown and safeguards are in place. |
| RCW 74.13.640 | PUBLIC ASSISTANCE | CHILD WELFARE SERVICES | CHILD FATALITY REVIEW—REPORT | DSHS directed to conduct a review and write a report in the event of an unexpected death of a minor who is in the care of or receiving services from the Department, or has been in the care of or receiving services within one year preceding the death. |

Appendix D:

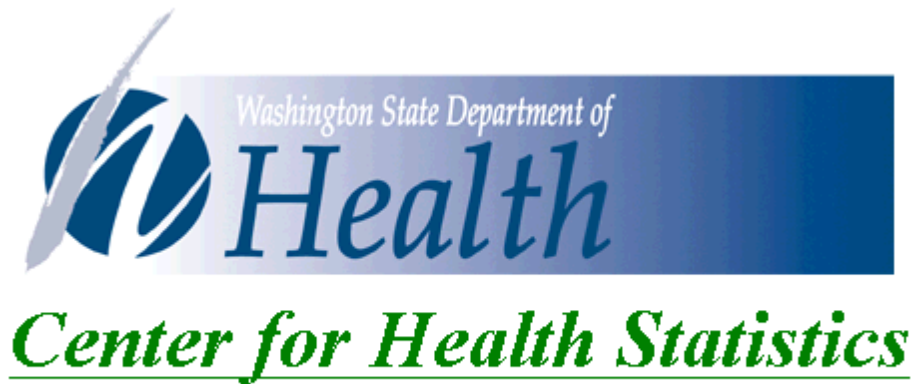
Early Notification of Childhood Death ENCD *Instruction Manual*



Center for Health Statistics

September 2001
Contact : Phyllis Reed
Center for Health Statistics
Washington State Department of Health
Email: Phyllis.reed@doh.wa.gov
TEL: (360) 236-4324

ENCD Logon Screen



Logon Page

*Access to this system is restricted to
authorized personnel and agents of the Department of Health.
System use may be logged and monitored.
See RCW 9A.48.100, 9A.52.110 and 9A.52.120*

Name:

Password:

- Name = name of county
- Password = 5 digit field
 - 2 digit state code (48)
 - 1 digit constant = 7
 - 2 digit county code numbered alphabetically 1-39

The logon name and password system can be changed to suit local needs. To create a more secure system, we can develop unique identifiers and passwords with periodic re-assignment of passwords.

Navigational Guidelines

The ENCD system is designed primarily for keyboard functions using drop-down boxes with limited direct data entry. Here are some hints for using the system:

To move from field to field

Example: Logon Name and Password

❖ use TABS



'Tab' to "NAME" field and enter the county name, press 'Tab' to move to "PASSWORD" field.

❖ OR use MOUSE.



Left click on the "NAME" field and type in the county name, then hit 'enter' to move to "PASSWORD."

To enter a date

Example: Date of Death – start of date range – "from" month

❖ use DROP-DOWN boxes, ARROW KEYS and TABS



'Tab' to the first box and use the ↑ ↓ to highlight the month, then press 'Tab'.

❖ OR use DROP-DOWN boxes, ARROW KEYS and MOUSE.



Left click on box with the down arrow and left click on the month.

❖ OR use DROP-DOWN boxes, TOGGLES, and TABS



Enter the first letter of the month, such as "A" to select "April."

If there is more than one month with the same letter, enter the letter repeatedly until the correct month appears. For example, "J" selects "Jan" the 1st time, "Jun" the 2nd time, and "Jul" the 3rd time. (Note: Similar toggles exist for day of month, where "0" selects 01, 02, 03, etc. and "1" selects 10, 11, 12, etc., and for year where "1" selects the first year in the series (to be given with most recent year first.)

Search Screen

| On-line ENCD Search | |
|--|--|
| Date-of-Death: from <input type="text"/> <input type="text"/> <input type="text"/> - to - <input type="text"/> <input type="text"/> <input type="text"/> | |
| County of Injury: <input type="text"/> | |
| County of Residence: <input type="text"/> | |
| County of Occurrence: <input type="text"/> | |
| Date Posted: from <input type="text"/> <input type="text"/> <input type="text"/> - to - <input type="text"/> <input type="text"/> <input type="text"/> | |
| <input type="button" value="Search"/> <input type="button" value="Reset"/> <input type="button" value="Add New Entry"/> <input type="button" value="Help"/> | |

Search Fields

Date of Death – Enter the date range for searching records “from” and “to” specified dates using the format mm dd yyyy (06 25 1998). An open-ended search can be created by filling in either the beginning of the date range (“from”) or the end (“to”).

County of Injury – County in which the child’s injury occurred.

County of Residence – County in which the child was living at the time of death.

County of Occurrence – County in which the child’s death occurred.

Date Posted – Date on which the child’s information was posted to the ENCD system. An open-ended search can be created by filling in either the beginning of the date range (“from”) or the end (“to”).

The five fields on the Search Screen are divided into two groups:

Group # 1

- Date of Death.
- County of Injury.
- County of Residence.
- County of Occurrence.

Group # 2

- County of Occurrence.
- Date Posted.

A search can be conducted using a single field or up to 4 fields from Group 1 or up to 2 fields from Group 2. The two groups are independent so that a search can be conducted using fields in either Group 1 or Group 2. "Date Posted" can be used alone or with "County of Occurrence," but it cannot be used with any of the other items from Group 1 (i.e., Date of Death, County of Injury, or County of Residence).

WARNING: Date Posted will supercede searches based on Date of Death, County of Injury, or County of Residence if one enters search criteria in these fields jointly.

Examples

To search for all the death records that occurred in King county:

- ❖ At County of Occurrence arrow down, click the mouse button and select King for King County.
- ❖ Then move the cursor to Search button and click on it.

To search records of those who lived in Thurston County and died between 1/01/1999 and 01/12/1999:

- ❖ At 'from' of Date of Death field select Jan. 1, then 1999
- ❖ At 'to' of Date of Death field select Jan. 12, then 1999.
- ❖ At County of Residence select Thurston.
- ❖ Then click on Search button.

To search those records that were posted date between 6/6/1999 and 6/10/1999:

- ❖ At 'from' of Date Posted field select Jun. 6, then 1999
- ❖ At 'to' of Date Posted field select Jun. 10, then 1999.
- ❖ Then click on Search button.

Navigation Tools

Reset – to clear your screen entry.

Add New Entry – to go to the data entry page.

Help – to display information about how to use this screen.

Back (at top of screen) – to go back to the LOGON Screen

Search Results

On-line ENCD Search Result Page

There are 62 records found in your selection.
*Select a record and press the **View** push button to view the full record,
or press the **Back** push button to return to **Search Page**.*
Or [Click here to Down Load your search result.](#)

| | |
|---|--|
| 000002 ANTHONY DELEON M 400 `Jan 02 1989` #123 | |
| 000003 MIRANDA BIXLER F 201 `Jan 11 1985` #133 | |
| 000009 DALE BREWER M 201 `Jan 28 1982` #189 | |
| 000011 ALMA RAMIREZ F 001 `Feb 07 1991` #203 | |
| 000014 ALBERTO CASTRO M 002 `Feb 16 1988` #218 | |
| 000016 JESSICA MENDEZ F 205 `Apr 12 1983` #232 | |
| 000018 IGNACIO TAPIA M 400 `Mar 21 1995` #251 | |
| 000019 RALPH GILLIAM M 401 `Feb 28 1984` #256 | |
| 000021 MATTHEW NICHOLS M 404 `Mar 18 1994` #279 | |
| 000027 CESAR RAMIREZ M 409 `Mar 01 1996` #324 | |

View

<< Back

This is the Search Result screen. From this screen you can choose to view or download any of the child's information that is on the screen.

To view



TAB to the smaller box, then use $\uparrow \downarrow$ to select the record. **TAB** to the View button and press the **SPACEBAR**.



Left click on the record, then left click on the View button.

| On-line ENCD - View Page | | | | | |
|--|--|-----------------------------------|--|---------------------------------------|--|
| Local-Cert-Number: 123456 | | | | | |
| First name | | Last name | | Sex | |
| ANTHONY | | SMITH | | M | |
| Date-of-Death: Jan 02 1989 | | Date-of-Birth: Jan 02 1989 | | | |
| Age(Code): 400 | | County-of-Death: 701 | | Social Security #: 123-45-6789 | |
| Residence Address: | | | | | |
| Street: 1000 E ANYWHERE | | | City: OLYMPIA | | |
| County: 734 | | State: WA | | Zip: 98XXX | |
| Mother-First-Name: XXXXXX | | | Maiden-Name: YYYYYY | | |
| Medx-Coroner-File-Number: XXXXXX | | | Birth-Certificate #: 1989-R-12345 | | |
| Autopsy: 2 | | Medx-cor/Ref: 2 | | Death-Type-Code: 1 | |
| | | | | Injury-County: 999 | |
| Data-Source: 734 | | Date Posted: 19980403 | | | |
| << Back Help | | | | | |

To exit view



TAB to the Back button and press **SPACEBAR**.



Left click on the Back button.

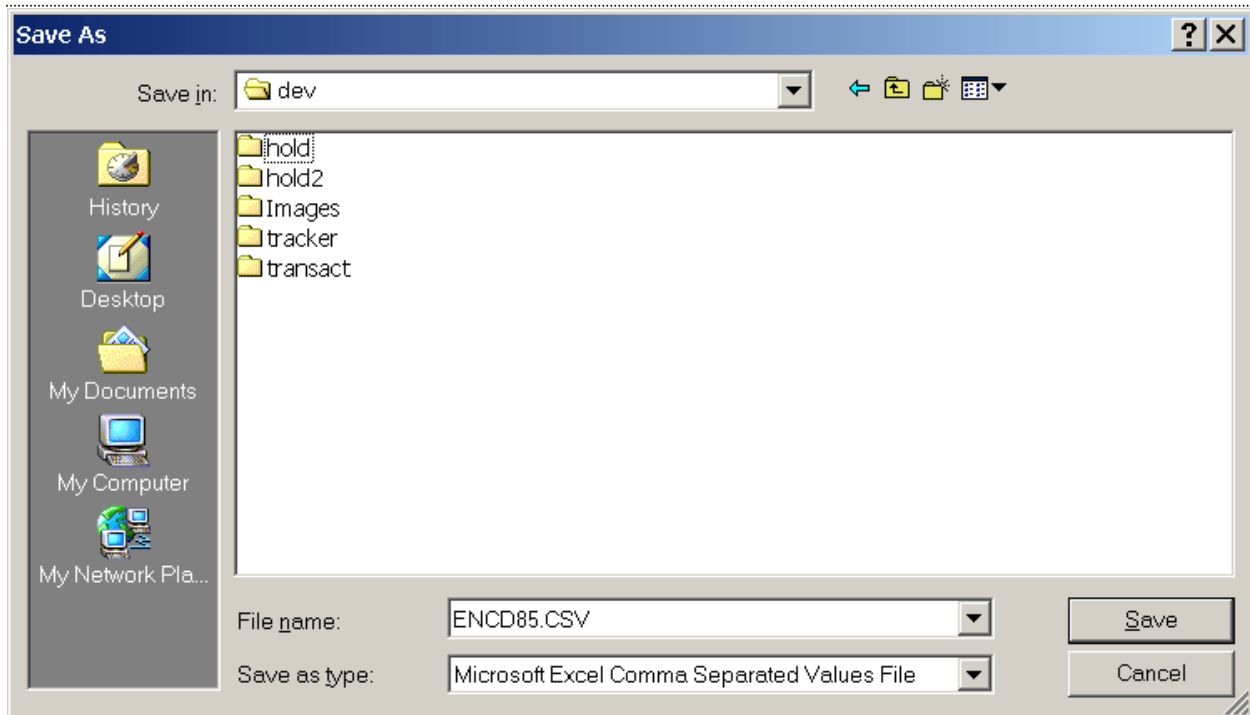
To download



TAB to the blue letters “Click here to Down Load your search results” and press **SPACEBAR**.



Left click on the blue letters “Click here to Down Load your search results”.



Choose a file name and the directory where you would like your file to be located at.

Entry Form Screen

| ENCD Entry Form | | | |
|--|--|---|--|
| Local File Number: <input type="text"/> | | | |
| First name <input type="text"/> | | Last name <input type="text"/> | |
| | | Sex <input type="text"/> | |
| Date-of-Death: <input type="text"/> | | Date-of-Birth: <input type="text"/> | |
| Age(Code): <input type="text"/> | | County-of-Death: <input type="text"/> | |
| | | SSN: <input type="text"/> | |
| Residence Address | | | |
| Street: <input type="text"/> | | City: <input type="text"/> | |
| County: <input type="text"/> | | State: <input type="text"/> | |
| | | ZIP: <input type="text"/> | |
| Mother Firstname: <input type="text"/> | | Maiden-Name: <input type="text"/> | |
| Medx-Coroner-File #: <input type="text"/> | | Birth-Certificate #: <input type="text"/> | |
| Autopsy: | | <input type="radio"/> Yes, Was Examined <input type="radio"/> No, Was Not <input type="radio"/> Not Reported <input type="radio"/> Unknown | |
| Medx-Cor/Ref: | | <input type="radio"/> Yes, Was Referred <input type="radio"/> No, Was Not <input type="radio"/> Not Reported <input type="radio"/> Unknown | |
| Death-Type: | | <input type="radio"/> Natural Causes <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending | |
| County of Injury: <input type="text"/> | | | |
| <input type="button" value="Submit"/> <input type="button" value="Reset"/> <input type="button" value=" << Back"/> <input type="button" value="Help"/> | | | |

This is the Entry Form Screen that allows you to enter information about a child who has died. There are eight mandatory fields: Local File Number, Sex, Date of Death, Date of Birth, Age, County of Death, County of Residence, and County of Injury. These are highlighted in red.

All information (except the birth certificate number) is to be taken from the death certificate. The item number from the death certificate is shown after each data entry field below.

Local File Number – number assigned by local registrar which appears in the upper left-hand corner of the death certificate

First Name – first name of the child as it appears on the death certificate (item 1)

Last Name – last name of the child as it appears on the death certificate (item 1)

Sex – gender of the child (F – female; M – Male; U – Unknown (rare event but may occur)) (item 2)

Date of Death – Month – month in which death occurred, shown as a 3-letter abbreviation (item 3)

Date of Death – Day – day on which death occurred, shown as a 2-digit number with numbers less than 10 shown with a preceding 0, as 01, 02, 03, etc. (item 3)

Date of Death – Year – year in which death occurred, shown as a 4-digit number (item 3)

Date of Birth – Month – month in which child born, shown as a 3-letter abbreviation (item 7)

Date of Birth – Day – day on which child born, shown as a 2-digit number with numbers less than 10 shown with a preceding 0, as 01, 02, 03, etc. (item 7)

Date of Birth – Year – year in which child born, shown as a 4-digit number (item 7)

Age (Code) – 3-digit field. The first digit represents the age units, and the last two digits represent the number of those age units. The age units may be one of the following values:

- 0 – age in years
- 2 – age in months
- 3 – age in weeks
- 4 – age in days
- 5 – age in hours
- 6 – age in minutes

Examples:

- 012 = 12 years old
- 204 = 4 months old
- 413 = 13 days old

NOTE: If the date of birth equals the date of death, the ENCD system will prompt you to enter the age in hours (as 5##) or in minutes (as 6##).

County of Death – county in which the death occurred (item 10)

SSN – Social Security Number of the child, enter as ###-##-#### (item 16)

Residence – Address – address of child at time of death

Street – number and street (and apartment number, if applicable) (item 22)

City – city of residence, entered in full (item 23)

County – county of residence, entered in full (item 25A)

State – state of residence, entered as a two-letter abbreviation (item 26)

Zip Code – 5-digit zip code of residence (item 27)

Mother’s First Name – first name of mother, as shown on the death certificate (item 29)

Mother’s Last Name – last name of mother, as shown on the death certificate (item 29)

Medx Coroner File Number – medical examiner or coroner file number (item 49)

Birth Certificate Number – birth certificate number (to be obtained from the ABC system prior to entering information into the ENCD system; to be used by CHILD Profile). If discrepancies between information on the death and birth certificates are found (e.g., differences in the names given for the child or mother), do NOT enter a birth certificate number on the ENCD system.

Autopsy – information about whether an autopsy was performed (item 52)

Check one of the following categories:

Yes, Was Examined

No, Was Not

Not Reported [item blank on the death certificate]

Unknown [unknown specified on the death certificate]

Medx Cor/Ref – response to the question: “Was case referred to medical examiner or coroner? as shown on the death certificate (item 53)

Check one of the following categories:

Yes, Was Referred

No, Was Not

Not Reported [item blank on the death certificate]

Unknown [unknown specified on the death certificate]

Death Type – Type of death as indicated in the cause of death section of the death certificate.

Check one of the following categories:

Natural causes (use when death not due to accident, suicide, homicide, or undetermined injury)
Accident
Suicide
Homicide
Undetermined
Pending [investigation into cause of death]

Injury County – County in which the injury occurred which may or may not be the same as the county of death (to be determined from item 60 – location of injury; see city/county table in Appendix A)

Submit, Reset, and Back – Navigation buttons that allow you

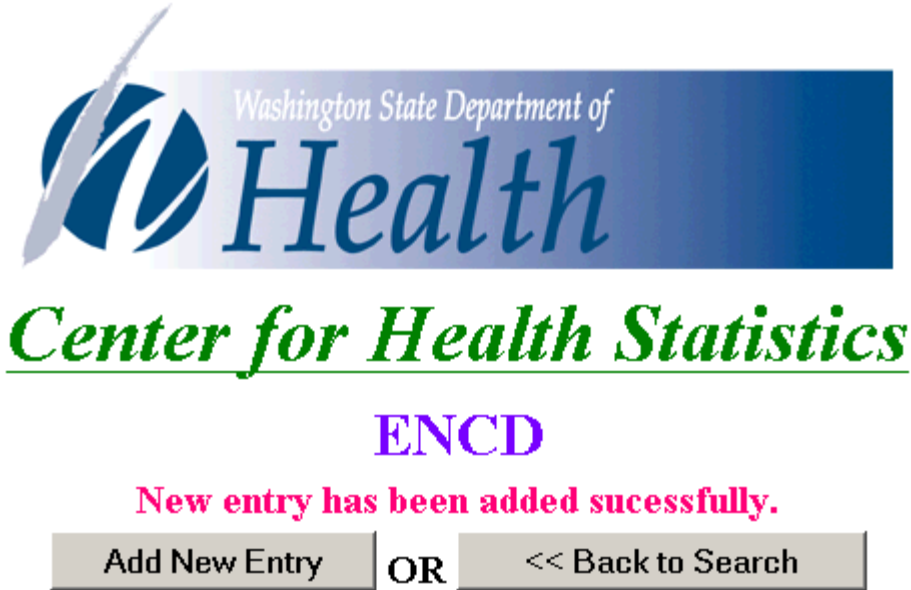
- ❖ to submit the new records as entered,
- ❖ reset to clear all fields and start over, or
- ❖ go back to the search screen.

Once a record has been submitted, corrections cannot be made within the local health district. Any errors in the information that are found subsequently must be corrected by staff from the Center for Health Statistics. Please contact Tami Jones at (360) 236-4339 to make such corrections.

Submit Screen

You will get one of these screen after you submit your new entry

If your entry was successfully added, this screen will appear.



Add New Entry –To add another entry.

Back to Search – This will get you back to the Search Screen.

If your try to re-submit the same record, this screen will appear.



E.

SAMPLE

SPokane County Child Death Review Committee
CONFIDENTIALITY STATEMENT FOR VISITORS

Spokane County Child Death Review Committee (SCCDRC) meetings may consider issues relating to professional practices, specific practitioners, or specific patients. Washington state code provisions protect the confidentiality of records used, case material discussed, and communications between participants. To protect all those involved and to ensure the integrity of SCCDRC proceedings, such confidential information shall not be revealed to or discussed with anyone except a committee member or staff of a member agency with a legitimate professional interest in the proceedings.

Periodically, the SCCDRC may solicit information and presentations from consultants in the prevention, identification, or treatment of child abuse and neglect cases, representatives of agencies involved in those processes, or authorities in related fields. As such a consultant, I am aware of the confidentiality policy described above and will not reveal any case-identifying information to anyone other than SCCDRC members.

Name (print): _____
Signature: _____
Agency: _____
Date: _____

SPokane County Child Death Review Committee
CONFIDENTIALITY STATEMENT FOR COMMITTEE MEMBERS

Spokane County Child Death Review Committee (SCCDRC) meetings may consider issues relating to professional practices, specific practitioners, or specific patients. Washington state code provisions protect the confidentiality of records used, case material discussed, and communications between participants. To protect all those involved and to ensure the integrity of SCCDRC proceedings, such confidential information shall not be revealed to or discussed with anyone except a committee member or staff of a member agency with a legitimate professional interest in the proceedings.

As a member of the SCCDRC, I certify that I am trained in the prevention, identification, or treatment of child abuse and neglect cases and/or represent an agency that is involved in those processes. I am aware of the confidentiality policy described above and will not reveal any case-identifying information to anyone other than SCCDRC members and staff members of agencies represented on the SCCDRC. By affirming this confidentiality statement, agency representatives on the SCCDRC affirm that any staff member of their agency with access to SCCDRC proceedings agrees to abide by this confidentiality statement.

Name (print): _____
Signature: _____
Agency: _____
Date: _____

E.

SAMPLE

DATE:

TO:

Subject: Medical & Case Records requested by the Snohomish Health District.

The Snohomish Health District, as part of the Child Death Review Committee, requests the following medical and case records at your earliest convenience.

This request is made pursuant to RCW 70.05.170 and will be used solely for the purposes of the Committee's review. Information presented during the review process is protected from discovery or subpoena in any legal proceeding related to the death, unless the information is otherwise subject to discovery or subpoena.

If the medical record is brief, please copy the entire record. If it is lengthy, we would appreciate copies of the following : emergency department records to include medicines administered, procedures performed, laboratory tests, death and discharge summaries, and any post-mortem evaluations. Please contact Lynda Benak, Coordinator-Child Death Review or Kathy Kimsey at (425) 339-5290, ext. 514 when the records are available.

| <u>Name of Decedent</u> | <u>Date of Birth</u> | <u>Date of Death</u> | <u>Place of Death</u> |
|-------------------------|----------------------|----------------------|-----------------------|
| | | | |

We appreciate your assistance in this process. If you should have additional questions or if we can assist you in any way, please contact our office.

Sincerely,

M. Ward Hinds, MD, MPH
Health Officer
Snohomish Health District

Norman Thiersch, MD
Chief Medical Examiner
Snohomish County Medical Examiner

Cc: Diane Gordon, Snohomish Health District

**CHILD DEATH REVIEW
TRACKING WORK SHEET**

COUNTY OF RESIDENCE _____ COUNTY OF DEATH _____

NAME _____ DOD: _____ DOB: _____

| | | | |
|--|-------|----------------------------|-----------|
| Medical Examiner/Coroner Case: | | Yes | No |
| Jurisdiction: | | Contact: | |
| SIDS Case: | | Yes | No |
| | | PHN Contact: _____ | |
| Hospital Medical Records Needed | | Yes | No |
| Hospital Records Requested | _____ | Facility: _____ | |
| Hospital Records Received | _____ | Contact: | |
| Physician Medical Records Needed: | | Yes | No |
| Physician Records Requested | _____ | Name: _____ | |
| Physician Records Received | _____ | | |
| Autopsy Report Needed: | | Yes | No |
| Autopsy Report Requested | _____ | Jurisdiction: _____ | |
| Autopsy Report Received | _____ | Contact: | |
| EMS Report Needed: | | Yes | No |
| EMS Report Requested | _____ | Jurisdiction: _____ | |
| EMS Report Received | _____ | Contact: | |
| Law Enforcement Report Needed: | | Yes | No |
| Law Enforcement Report Requested | _____ | Jurisdiction: _____ | |
| Law Enforcement Report Received | _____ | Contact: | |
| Prosecution Information Needed: | | Yes | No |
| Prosecution Information Requested | _____ | Jurisdiction: _____ | |
| Prosecution Information Received | _____ | Contact: | |
| CPS Information Needed: | | Yes | No |
| CPS Information Requested | _____ | Jurisdiction: _____ | |
| CPS Information Received | _____ | Contact: | |
| Other Information Needed: | | Yes | No |
| Requested | _____ | Contact: _____ | |
| Received | _____ | | |

Dates Reviewed: 1st _____ 2nd _____ 3rd _____

DATE REVIEW COMPLETED _____

Appendix F: SELECTED LIST OF REPORTS USING CDR DATA (DOH AND CDR)

Washington State Department of Health Publications

CDR Program Progress Report 2001

http://www.doh.wa.gov/Publicat/CDR_Program_Progress_Report.PDF

Series of Injury Prevention Recommendations Reports from State CDR State Committee at:

<http://www.doh.wa.gov/cfh/mch/cahcp/cdr.htm>

- For All Our Children (Preventing Motor Vehicle and SIDS Deaths) (2003)
- Child Firearm Death Prevention (2003)
- Childhood Drowning Prevention (2004)

Maternal and Child Health Data Report (2003):

http://www.doh.wa.gov/cfh/mchas/mchdatareport/mch_data_report_home.htm

Health of Washington State 2002: <http://www.doh.wa.gov/HWS/default.htm>

Community Norms about Child Abuse and Neglect:

<http://www.doh.wa.gov/EHSPHL/Epidemiology/NICE/publications/CommNormsChAbuse.doc>

Washington State Childhood Injury Report (2004)

Highlights leading causes of childhood injury; includes data on deaths and hospitalization, trends, disparities and selected CDR data for each cause of death chapter. Includes ‘Best practice’ prevention strategies for parents and communities

http://www.doh.wa.gov/cfh/injury/pubs/childhood_injury_report.htm

Use of Washington CDR Data in National Studies:

National Safekids drowning report “Clear Danger”:

<http://www.safekids.org/NSKW.cfm>

National KidsNCars injury database and subsequent

articles: <http://www.kidsandcars.org/>

Local Health Jurisdiction Reports:

Motor Vehicle Crashes with Child Fatalities: *Summary of Snohomish county Child Death Review Data January 1, 1999 - October 31, 2002*

(http://www.snohd.org/button_pages2/info.htm)

Spokane Child Death Review Reports (1996-1999, 2000-2001)

<http://www.srhd.org/information/pubs/assessmentepidemiology.asp>



APPENDIX G: EFFECTIVE TEAM MEETINGS

Tips for Effective Review from Washington CDR teams (September 2003)

- ❖ Abstract key information onto the form prior to the review:
- ❖ Build relationships with agencies- this will improve your access to needed information.
- ❖ Make sure the key parties are at the table for the review: i.e. the traffic safety person for MVC deaths, the tribal representative for Native American deaths, etc.
- ❖ Make sure team members know, ahead of time, which deaths are to be reviewed so that they can either send in what information they have - ahead of the review - or bring it to the review process.
- ❖ At the review, provide a summary of events surrounding the death which leads into a discussion on the larger issues (committee conclusions) rather than have the team focusing on filling in every gap. Don't interrupt flow of discussion to fill in every data gap. Once discussion is complete, go back and try to fill in gaps.
- ❖ Incorporate an injury prevention specialist to help team develop evidence-based prevention recommendations.
- ❖ Review similar types of deaths together (i.e. drowning deaths) and invite an expert as a guest to help drive injury prevention efforts and improve data collection.
- ❖ Don't be afraid to table the review in order to obtain more information.
- ❖ Support the Team in the Work They Do
 - It is comforting to have the difficult nature of the process acknowledged. There is an awesome dynamic at most of our meetings. Primarily having a belief that what we do is of value and can make a difference in the lives of children (and keeping an eye on the bigger public health picture) seems to drive the process. Also a recognition of the high caliber of professionals around the table and the amazing commitment to their work, and the opportunity to learn from each other, including guests, seems to be another component that keeps most meetings upbeat.
 - I found it helpful to have the various disciplines present for committee. Often their knowledge of discipline-specific laws or practices helped address the angst about why things did or did not happen.
 - Food: Truly lots of treats help, my department has allotted budgeted amount for food items- chilled bottled water, lots of chocolate, we meet late afternoon so some cheese and crackers, fruit- this may seem superfluous (and really doesn't cost much) but creating an environment that is upbeat and very appreciative of folks time and expertise- as the facilitator is what I try to convey.
 - We usually skip August and December due to vacation schedules and taking a break from the reviews really helps with perspective.
 - Acknowledge that the review has been an unusually difficult meeting and thank everyone for a job well done and for staying by for the whole meeting. I also try to acknowledge if we were able to identify some things of significance as a result of our discussion
 - Stop by a cathedral on the way back to the office after previewing records for a few minutes of quiet time. It helps separate from the sadness of it all.
 - Keep a lighter schedule or leaving earlier on the afternoon after a meeting.

- In order to do their day-to-day work, team members have had to develop a set of coping skills to be able to function in their chosen line of work. Some of the team members, inherently come equipped with self-care skills.
- Talk with a co-worker about the difficulty without getting specific about information from agencies other than their own.

For particularly devastating cases, consider a formal "Critical Incident Debriefing" process.

Appendix H:

Updated October 2004

Disclosures for Public Health Under HIPAA: The HIPAA Privacy rule recognizes the legitimate need for public health authorities and others responsible for assuring public health and safety to have access to protected health information to carry out their public health mission. As stated under the Privacy Rule of HIPAA, a covered entity may disclose protected health information without authorization from the individual to “a protected health authority that is authorized by law to collect or receive such information for the purpose of prevention or controlling disease, injury or disability, including but not limited to the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.” (Section 164.512(b)(1)(i)). Additionally, disclosure may be made to “a public health authority or other appropriate government authority authorized to receive reports of child abuse and neglect.” A public health authority is defined as federal, tribal, state, or local public agency, or person or entity acting under a grant of authority from such public agency that is responsible for public health matters.

Child Death Review and HIPAA: Child Death Review (CDR) is a public health program administered by Washington’s public health agency, the Department of Health (DOH) through local health jurisdiction-based review teams. RCW 70.05.170 authorizes teams based in local health jurisdictions to perform CDR and provides for the publication of statistical compilations and reports related to the team’s review so long as the summaries or reports do not identify the individual cases or sources of information. Disclosures to CDR teams that are acting under the auspices of a public health agency are permissible under HIPAA.

CDR’s Information Sharing Policy: Although the HIPAA Privacy Rule does not directly apply to CDR, DOH is prohibited from disclosing identifiable data from the CDR database under RCW 70.05.170. CDR data are submitted to DOH and maintained in a confidential database, per RCW 43.70.050, which authorizes the collection, utilization, and accessibility of health-related data, by the secretary of health. Data submitted to the state are treated as confidential and are reported in aggregate form only and for public health purposes.

References:

The following resources are provided for your convenience.

- HIPAA Fact Sheet on DOH Website: <http://www.doh.wa.gov/OS/HIPAA/default.htm>
- HIPAA Privacy Rule and Public Health Guidance from CDC and the U.S. Department of Health and Human Services <http://www.cdc.gov/mmwr/pdf/other/m2e411.pdf>
- National Clearinghouse for CDR HIPAA website: <http://www.childdeathreview.org/hipaa.htm>
- “The Fetal and Infant Mortality Review Process: The HIPAA Privacy Regulations.” The National Fetal and Infant Mortality Review Program, the American College of Obstetrics and Gynecology, 2003.

Please note: *This document is not intended to provide legal advice, and you are encouraged to seek your own counsel regarding HIPAA. Document available at:*
<http://www.doh.wa.gov/cfh/mch/cahcp/cdr.htm>

APPENDIX I: Selected CDR-Related Links

Washington State CDR Links:

Washington State Department of Health Child Death Review website:

<http://www.doh.wa.gov/cfh/mch/cahcp/cdr.htm>

CDR web-Based Reporting Manual: http://www.doh.wa.gov/cfh/CDR/cdr_tableofContents.htm

CDR Data Form: http://www.doh.wa.gov/cfh/mch/documents/cdr_form.pdf

Harborview Injury Prevention and Resource Center Project: Improving Injury Prevention Capacity in the Child Death Review Process

<http://depts.washington.edu/hiprc/projects/risk/cdrt.html>

National CDR Links:

National MCH Center for Child Death review: <http://www.childdeathreview.org/>

The National Center on Child Fatality review: <http://www.ican-ncfr.org/>

Michigan Child Death Review Program: <http://www.keepingkidsalive.org/>

Arizona Child Fatality Review website: <http://www.azdhs.gov/phs/owch/cfr.htm>

Injury-Related Links:

Centers for Disease Control and Prevention National Center for Injury Prevention and Control:
<http://www.cdc.gov/ncipc/>

Harborview Injury Prevention and Resource Center: <http://depts.washington.edu/hiprc/>

Harborview grant: Improving Injury Prevention Capacity in the Child Death Review Process:
<http://depts.washington.edu/hiprc/projects/risk/cdrt.html>

Evaluation:

Community Toolbox: Evaluating Community Programs and Initiatives:

http://ctb.ku.edu/tools/en/section_1338.htm

Centers for Disease Control and Evaluation: Evaluation Framework

<http://www.cdc.gov/eval/framework.htm>

<http://www.phppo.cdc.gov/phtn/Pract-Eval/workbook.asp>

Basic Guide to Program Evaluation:

http://www.mapnp.org/library/evaluatn/fnl_eval.htm#anchor1575679

WH Kellogg Foundation Evaluation Tools:

<http://www.wkkf.org/Programming/Overview.aspx?CID=281>

Community Guide to Preventive Services: <http://www.thecommunityguide.org/>

Community Health Worker Evaluation Toolkit (University of Arizona)

<http://www.publichealth.arizona.edu/chwtoolkit/PDFs/Evalua/evalua.pdf>

Results & Performance Accountability Implementation Guide <http://www.raguide.org/>

Getting to Outcomes: Methods and Tools for Planning, Self-Evaluation and Accountability

http://www.stanford.edu/~davidf/GTO_Volume_I.pdf

http://www.stanford.edu/~davidf/GTO_Volume_II.pdf

On-line how-to guide for program evaluation.

http://www.mapnp.org/library/evaluatn/fnl_eval.htm

APPENDIX J: EXAMPLES OF ETHICAL DILEMMAS FROM NATIONAL CDR MANUAL

| Ethical Dilemmas | | |
|---------------------|---|--|
| Topic | Situation | Dilemma |
| Team Membership | Your team plans to conduct a case review of a ten-year-old pedestrian that was killed by an intoxicated driver. This driver is the cousin of a CDR team member. | Should the team ask this person to recuse himself from the meeting? |
| | You are a small county, reviewing 4-5 deaths a year. You are planning to review a SIDS death at your next meeting. You receive a call from the father of this infant, asking that he and his wife attend the meeting so that they can learn more about your findings in an effort to understand why their child died. | Should parents be informed that you are reviewing their child's death? Upon request, should parents be invited to attend your meetings? Should parents be provided with findings resulting from your review? |
| | Children from racial and ethnic minority groups have much higher death rates in most categories of deaths in your jurisdiction. Your team is reviewing findings and making recommendations. However, your team has no representatives from these racial and ethnic groups. | Should your team make recommendations for prevention on all deaths they review or seek broader representation? |
| Case Selection | You are planning to review two deaths due to fires at your next meeting. You do not have any persons on your team with expertise in fire investigation or prevention. You think you should add someone to the team, but others feel that a new member would upset the excellent team dynamic you have all worked hard to achieve. | Should you review a case in which your team lacks expertise? |
| Sharing Information | You are a Child Protective Services supervisor serving on your county's CDR team. Next month, the team is reviewing a child abuse homicide. You have knowledge that a caseworker under your jurisdiction did not follow agency policy when investigating prior charges of abuse with this child. | Do you share this information about your employee with the team? |
| | You are the public health representative on your team and as a nurse conducted many home visits supporting a young mother and her infant. The infant died at 10 months due to a treatable infectious disease. | Do you present information at the review that was shared by the young mother during your home visits with her? |
| | You are the county prosecutor, waiting for information on a potential child neglect death. You know you could get information at the review that may either help you build a case or give you exculpatory information you may have to share with the defense. | Should you attend the review? |
| Use of Information | During your review of a homicide, conflicting opinions are shared by team members as to the circumstances of this death. Your prosecutor is not in attendance. | Should someone on your team inform the prosecutor of the information, some of which may by law need to be shared with the defense (exculpatory)? |
| | You are a member of your county's Fetal and Infant Mortality Review Team. Case information shared at that review is de-identified. You obtain information on a specific case at CDR. | Do you share this with the FIMR coordinator or at the FIMR review? |
| | You participate on the review team, representing the county prosecutor's office. You obtain information at the review related to product safety, leading you to believe the family could successfully win a civil settlement for damages. | Should this information be shared with the family or their attorney? |
| | You live in a very small county. The press would like to write a story to promote safety and has asked your team to share general findings. You are concerned that everyone in your community would know which death is being discussed. | Do you provide the press with your findings? |

Introduction

Preventable deaths and injuries are a leading cause of child mortality in the U.S. In 2001, more than 10,000 children aged 0-18 died from unintentional injuries and nearly 3,500 children died from homicide or suicide in the U.S.¹ According to the Centers for Disease Control and Prevention (CDC), the leading causes of fatal childhood injuries are motor vehicle accidents, fires/burns, drowning, falls, and poisoning.²

Many states have implemented a Child Death Review (CDR) system to more accurately track and determine the cause of child deaths and to help prevent future deaths from occurring. Child death review programs provide a forum to work with multidisciplinary teams at the state and local level to facilitate the process of reviewing all child deaths. Most child mortality data are based on information collected from death certificates. However, research has shown that death certificates frequently provide missing or incomplete information that may impede finding the true cause of death or its preventability. It is through the review of more comprehensive information, such as hospital records, medical examiner's reports, and death scene investigation data, that a more accurate assessment can be made.³ Child Death Review programs facilitate greater community collaboration to help ensure progress in child health and safety efforts.

Although state public health agencies are increasingly recognizing the need for comprehensive state-based CDR systems for their importance in aiding child death prevention efforts, sustaining these

programs can present real challenges amidst the fiscal pressures states are currently experiencing. This issue brief highlights some multidisciplinary, multiagency collaborations between state public health and other agencies to more efficiently and effectively prevent child deaths, outlines creative solutions that some states have taken to sustain funding for their CDR programs, and describes effective changes in policies and programs that have arisen as a result of recommendations made by CDR teams.

National Child Death Review Promotion Efforts

Child Death Review programs have received much endorsement at the national level. The Healthy People 2010 objectives include extending state-level child fatality review systems and reducing the rate of child deaths. The U.S. Public Health Service, the American Academy of Pediatrics (AAP), the Department of Health and Human Services' Office on Child Abuse and Neglect, the Department of Justice, and the American Bar Association have all endorsed CDR. Despite these CDR promotion efforts throughout the U.S., no standardized criteria for CDR programs currently exist.⁴ However, new efforts to establish national guidance by the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) continue.

According to the AAP, "Although there is a continuing need for timely review of child deaths, no uniform system exists for investigation in the United States." The AAP recommends that public policy initiatives directed at preventing childhood

deaths, based on information acquired at the local and state levels from adequate death investigations, accurate death certifications, and systematic death reviews, be supported at the national level.⁵

In 1992, MCHB convened a CDR advisory group which recommended that the primary purpose of child death review should be prevention and that CDR teams should “implement the most expansive and comprehensive approach for identifying cases.” A decade later, MCHB funded the National MCH Center for Child Death Review^{*} with the goal of providing technical assistance, training and support to states to build the capacity for a public health-based approach to child death review.

Integrating Child Death Review into Public Health

The nation’s first CDR teams began in the late 1970s, in Los Angeles, Oregon, and North Carolina. The purpose of these teams was to analyze child deaths resulting from caregiver abuse or neglect. In the last 25 years, subsequent CDR programs have expanded their focus from child abuse and neglect to a more comprehensive, public health-based analysis of child fatalities, including unintentional deaths and injuries, suicides, other homicides, deaths due to perinatal conditions and other natural causes.

States vary in how they structure CDR, but at least 40 of them are structured such that a state program facilitates local reviews and a state advisory team to develop recommendations for improvements to state policy and practice to prevent child deaths. State and local CDR teams are generally multidisciplinary and multiagency in composition^{6, 7} with state public health

agencies increasingly collaborating with departments of criminal justice, social services, mental health and other agencies in the child death review process.

Forty-nine states and the District of Columbia currently have some type of CDR program in place, and seventeen of these state-based CDR programs are currently housed in the state public health agency. Though not all state CDR programs are based in public health, most programs include state and local health agencies as partners, with representatives from public health agencies often serving on Child Death Review Advisory Committees and Review Boards.

- In Michigan, 74 local child death review teams comprised of 1,170 professionals from more than 20 different disciplines and 76 counties met in 2000 to discuss their findings to develop recommendations for state policy to prevent future child deaths. State statute requires that, at a minimum, teams must include the county medical examiner, the prosecuting attorney, a law enforcement officer, and representatives from the **Michigan Department of Public Health** or local health agency, and the Family Independence Agency. Most teams have gone beyond this requirement and added representation from community mental health, education, emergency medical services, pediatricians, health clinics, hospitals, clergy, social work, fire departments, and tribal health and social services.⁸
- In 1995, under the Executive Order of the Governor, a Child Fatality Review Committee was established and the heads of the **New Hampshire Department of Health and Human Services**, the New Hampshire Department of Justice, and the New Hampshire Department of Safety signed an Interagency Agreement that defined the scope of information sharing and confidentiality within the Committee. Additionally, Committee members,

^{*} For more information on the National MCH Center for Child Death Review, visit www.childdeathreview.org or call 1-800-656-2434.

comprised of individuals from the public health, medical, law enforcement, judicial, legal, victim services, mental health, child protection, and education communities must sign confidentiality agreements in order to participate in the child death review process.⁹

State Legislation

Since 2000, all states have had some type of legal directive, including legislation or interagency agreements, in place for the establishment of a child death review process. However, these directives vary greatly across states, thereby making universal guidelines difficult to implement.

Of the 42 states that have passed CDR legislation, most mandate CDR while others provide for the discretionary formation of CDR teams.^{14, 15} Some national groups, such as the AAP, support state legislation and other efforts that establish comprehensive child death investigation and review systems at the local and state levels.¹⁶

- The Delaware legislature recently passed a law that requires expedited review of childhood deaths resulting from cases of child abuse and neglect. Mandatory review of these cases must be conducted within three months and the results must be reported to the Governor, the General Assembly, and the public within twenty days of review.¹⁷
- In 2000, House Bill 448 was passed mandating CDR Boards in each of Ohio's counties to review the deaths of children below the age of eighteen. The **Ohio Department of Health**, in partnership with the Ohio Children's Trust Fund and experienced CDR teams, organizes regional and statewide training for mandated local CDR review teams. Some of the training topics include conducting effective child death reviews, injury prevention strategies, CDR legal issues, turning

recommendations into action, death scene investigation, domestic violence and child maltreatment, and school-based prevention programs on adolescent suicide. In 2001, CDR board members from 82 counties were trained with a total of 264 statewide participants. Funding for this statewide initiative was provided by the Maternal and Child Health Block Grant (Title V).¹⁸

- According to a recent national child fatality review report, the legal mandates in 37 states have "Prevention" as a stated goal of CDR; twenty state mandates have the "Identification of Abuse and Neglect" as a stated goal; and 29 state mandates have identified "Evaluation and Improvement of Agency Function" as a stated goal.¹⁹

State Reporting and Surveillance Activities

The majority of state CDR programs have reporting and surveillance systems in place to collect information from the local reviews which are then published in state CDR annual reports. Most states have borrowed from one another in developing their case report tool. The National MCH Center for Child Death Review has spearheaded an effort to develop a standardized web-based reporting system for use by any state or local CDR program. Seventeen states are participating in the design of this system which will be piloted in 2004. States plan to report into this system so that a more comprehensive profile of CDR findings can be collected and compared among states. These findings will be used to help drive national child health and safety programs, policies and services.

From Review to Action: Changes in Policies and Programs

CDR programs have led to the modification or implementation of more effective child

death prevention policies and programs in many states at both the state and local level. These programs include promoting best sleep practices to reduce the risk of sudden infant death syndrome (SIDS), motor vehicle safety education, increased access to emergency mental health services, mandatory bike helmet use, and other prevention initiatives.

- Since motor vehicle crashes account for 40 percent of preventable deaths in **Arizona, the Department of Health Services' Child Fatality Review Program** supported increased enforcement and community education regarding the state's child safety restraint laws. The program also supported legislation to establish a graduated driver's license program for teens.²⁰
- In 2000, Michigan's CDR team made 212 local recommendations for child death prevention, 74 of which were being acted upon by local communities within three months. New initiatives included developing task forces, changing local ordinances, implementing community safety projects, media campaigns, and other educational materials on a myriad of health-related issues such as SIDS, suicide prevention, emergency mental health and grief counseling, drowning and fire prevention, helmet use, and safe driving practices.
- A recommendation made by Virginia's CDR program, housed in the Office of the Chief Medical Examiner under the Commissioner's Office in the **Virginia Department of Health**, to reduce unintentional injury deaths caused by motor vehicle crashes was picked up by the state legislature and made into law. All fines collected from this car safety program go toward funding car seats for low-income families.

Sustaining Child Death Review Programs

Many CDR programs cite lack of funding as the primary barrier to establishing or expanding their child fatality review systems. Various funding sources have been identified in legal mandates and annual reports, yet these sources have not been specifically allocated towards CDR. Hence, CDR teams are often comprised of volunteers who must juggle the demands of their primary job responsibilities along with the demands of sustaining effective CDR programs in their spare time.^{10, 11}

Funding for state-based CDR programs has traditionally been sparse and varies from \$0 to \$500,000 per program.[†] Funding sources include Title V Block Grants, state general funds, Federal Children's Justice Act funds, Child Abuse Prevention and Treatment Act (CAPTA) funds, Emergency Medical Services for Children (EMSC) grants, AAP grants, and private foundation donations. As detailed below, some states have utilized other creative funding sources to help support their CDR programs.

- For example, **The Alabama Department of Public Health's** CDR program is funded through its Children's First Trust Fund. This initiative was started through the efforts of advocates and legislators who wanted to improve the lives of Alabama's children and was officially implemented in 1998 after legislation was passed appropriating tobacco settlement monies to the fund. Alabama's CDR program receives a small portion of this tobacco settlement fund. Although this is an innovative source of funding, the settlement monies are appropriated year to year, making secured funding a continuous challenge.^{12, 13}

[†] Several state programs are currently unfunded.

- The CDR programs in the **Arizona Department of Health Services**, the Kansas Office of the Attorney General, and the Nevada Department of Social Services have all implemented additional surcharges on their child death certificates and/or autopsy reports which are used to support their respective CDR programs.

Conclusion

Child death review programs provide a comprehensive, evidence-based approach to understanding and preventing child mortality in the United States. State public health agencies have made significant progress in child death prevention efforts over the past decade; however current state fiscal pressures threaten to abate some of these advancements. CDR data and recommendations can help state and local public health agencies decide where to best invest their prevention dollars, thereby, allocating limited resources wisely and efficiently. Increased child fatality review program effectiveness may be achieved through the continued support and expansion of CDR infrastructure, the development of national standardized criteria for child death investigations and data collection, and the enactment of further legislation.

This issue brief was supported in part by Cooperative Agreement No. 1 HO3 MC00022 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration. ASTHO is grateful for their support. ASTHO would also like to thank Teri Covington, Director, National MCH Center for Child Death Review, for her insightful comments and review.

For additional information, or to share information about child death review programs in your state, please contact Manisha Singhal at msinghal@astho.org.

References

- ¹ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. WISQARS Leading Causes of Death Reports, 1999-2001. Available at <http://webapp.cdc.gov/sasweb/ncipc/leadcaus10.html>.
- ² Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Childhood Injury Fact Sheet. Available at www.cdc.gov/ncipc/factsheets/childh.htm
- ³ Rimsza ME, Schackner RA, Bowen KA, Marshall W. Can Child Deaths Be Prevented? The Arizona Child Fatality Review Program Experience. *Pediatrics*: Volume 110, Number 1. July 2002. Available at www.ican-ncfr.org/documents/Can%20child%20death%20be%20prevented-AZ-2002.pdf.
- ⁴ Webster RA, Schnitzer PG, Jenny C, Ewigman BG, Alario AJ. Child Death Review: The State of the Nation. *American Journal of Preventive Medicine*: Volume 25(1), pp 58-64. July 2003. Abstract available at www.ajpm-online.net/article/PIIS0749379703000916/abstract.
- ⁵ American Academy of Pediatrics. Investigation and Review of Unexpected Infant and Child Deaths. *Pediatrics*: Volume 104, Number 5, pp 1158-1160. November 1999. Available at <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/5/1158>.
- ⁶ Elster NR, Alcalde MG. Child Fatality Review: Recommendations for State Coordination and Cooperation. *Journal of Law, Medicine & Ethics*: Volume 31:2, pp 303-307. Summer 2003. Available at www.findarticles.com/cf_dls/m0DPE/2_31/106290273/p1/article.jhtml.
- ⁷ Webster RA, Schnitzer PG, Jenny C, Ewigman BG, Alario AJ. Child Death Review: The State of the Nation. *American Journal of Preventive Medicine*: Volume 25(1), pp 58-64. July 2003. Abstract available at www.ajpm-online.net/article/PIIS0749379703000916/abstract.
- ⁸ Michigan Child Death State Advisory Team. Third Annual Report. Child Deaths in Michigan. Fall 2002. Available at www.keepingkidsalive.org/pdf/MPHI_ChildReport.pdf.
- ⁹ The State of New Hampshire Child Fatality Review Committee. Fifth Annual Report. October 2002.
- ¹⁰ Elster NR, Alcalde MG. Child Fatality Review: Recommendations for State Coordination and Cooperation. *Journal of Law, Medicine & Ethics*: Volume 31:2, pp 303-307. Summer 2003. Available at http://www.findarticles.com/cf_dls/m0DPE/2_31/106290273/p1/article.jhtml.

¹¹ Webster RA, Schnitzer PG, Jenny C, Ewigman BG, Alario AJ. Child Death Review: The State of the Nation. American Journal of Preventive Medicine: Volume 25(1), pp 58-64. July 2003. Abstract available at <http://www.ajpm-online.net/article/PIIS0749379703000916/abstract>.

¹² Alabama Department of Children's Affairs. Children First Trust Fund. Available at <http://www.dca.state.al.us/CFTF.htm>

¹³ Keeping Kids Alive: The Center for Child Death Review. State Spotlight - Alabama. Available at

www.childdeathreview.org/spotlightAL.htm.

¹⁴ Elster NR, Alcalde MG. Child Fatality Review: Recommendations for State Coordination and Cooperation. Journal of Law, Medicine & Ethics: Volume 31:2, pp 303-307. Summer 2003. Available at

http://www.findarticles.com/cf_dls/m0DPE/2_31/106290273/p1/article.jhtml.

¹⁵ Alcalde MG, Elster NR. Child Fatality Review in the United States: A National Overview. Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine. Available at

<http://www.louisville.edu/medschool/ibhpl/publications/Child%20Fatality%20Review%20in%20the%20United%20States%20-%20A%20National%20Overview.pdf>.

¹⁶ American Academy of Pediatrics. Investigation and Review of Unexpected Infant and Child Deaths. Pediatrics: Volume 104,

Number 5, pp 1158-1160. November 1999.

Available at <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/5/1158>.

¹⁷ Alcalde MG, Elster NR. Child Fatality Review in the United States: A National Overview.

Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine.

Available at www.louisville.edu/medschool/ibhpl/publications/Child%20Fatality%20Review%20in%20the%20United%20States%20-%20A%20National%20Overview.pdf.

¹⁸ Ohio Department of Health and The Ohio Children's Trust Fund. Ohio Child Fatality Review Second Annual Report. September 2002. Available at www.childdeathreview.org/reports/Ohio%202002%20Annual%20Report.pdf.

¹⁹ Alcalde MG, Elster NR. Child Fatality Review in the United States: A National Overview.

Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine.

Available at <http://www.louisville.edu/medschool/ibhpl/publications/Child%20Fatality%20Review%20in%20the%20United%20States%20-%20A%20National%20Overview.pdf>.

²⁰ Rimsza ME, Schackner RA, Bowen KA, Marshall W. Can Child Deaths Be Prevented? The Arizona Child Fatality Review Program Experience. Pediatrics: Volume 110, Number 1. July 2002. Available at <http://www.ican-ncfr.org/documents/Can%20child%20death%20be%20prevented-AZ-2002.pdf>.

Child Death Review

The State of the Nation

Romi A. Webster, MD, MPH, Patricia G. Schnitzer, PhD, Carole Jenny, MD, MBA,
Bernard G. Ewigman, MD, MSPH, Anthony J. Alario, MD

Background: Child death review (CDR) is a mechanism to more accurately describe the causes and circumstances of death among children. The number of states performing CDR has more than doubled since 1992, but little is known about the characteristics of these programs. The purpose of this study was to describe the current status of CDR in the United States and to document variability in program purpose, scope, organization, and process.

Methods: Investigators administered a written survey to CDR program representatives from 50 states and the District of Columbia (DC), followed by a telephone interview.

Results: All 50 states and DC participated; 48 states and DC have an active CDR program. A total of 94% of programs agreed that identifying the cause of and preventing future deaths are important purposes of CDR. Assistance with child maltreatment prosecution was cited as an important purpose by only 13 states (27%). Twenty-two states (45%) review deaths from all causes, while six states (12%) review only deaths due to child maltreatment. CDR legislation exists in 33 states. Fifty-three percent of the CDR programs were implemented since 1996, and 59% report no or inadequate funding. CDR contributes to the death investigation process in seven states (14%), but the majority (59%) of reviews are retrospective, occurring months to years after the child's death.

Conclusions: CDR programs in the United States share commonalities in purpose and scope. Without national leadership, however, the wide variation in organization and process threatens to limit CDR effectiveness.

(*Am J Prev Med* 2003;25(1):58–64) © 2003 American Journal of Preventive Medicine

Introduction

In 1998, over 19,000 children aged 1 to 18 years died in the United States.¹ Twenty-six percent of these child fatalities were due to natural causes, while 74% resulted from injuries. Approximately 30% of these injury deaths were classified as intentional injuries (homicide, suicide) and 70% were classified as unintentional (accidents). Furthermore, estimates of annual child maltreatment (or child abuse and neglect) fatalities among children aged <18 years ranged from 1000 to 2600.² While these statistics provide an overview of the nature and magnitude of the problem of child death in the United States, both the accuracy and the level of detail provided by current data sources are inadequate for successful prevention.^{3–5}

The evidence regarding the limitations of current data sources for accurately documenting the cause and manner of death among children originates primarily from the child maltreatment literature. Accurate identification and description of fatal child maltreatment are challenging for several reasons: the ease with which child maltreatment can be concealed, inadequate investigations, a lack of information sharing among agencies, a lack of definition consensus, and the nature of International Classification of Diseases coding requirements.^{4,6,7} Based on studies conducted in Missouri and North Carolina, current available data sources (death certificates, child protective services, and law enforcement records) clearly underestimate the incidence of child maltreatment fatalities when used in isolation.⁶

Recognition of the inadequacy of current sources for accurately identifying the causes of unexpected death among children led to the development of child death review (CDR) programs. Generally, CDR is a multidisciplinary, multi-agency process designed to examine the causes and circumstances of child deaths. This process is based on the premise that maltreatment is more difficult to conceal and less likely to be missed when professionals from various agencies and disci-

From the Rhode Island Hospital, Department of Pediatrics, Brown Medical School (Webster, Jenny, Alario), Providence, Rhode Island; and Center for Family Medicine Science, Department of Family and Community Medicine, University of Missouri–Columbia (Schnitzer, Ewigman), Columbia, Missouri

Address correspondence and reprint requests to: Romi A. Webster, MD, MPH, Pediatric Health Associates, Hunnewell Ground, Children's Hospital, 300 Longwood Avenue, Boston MA 02115. E-mail: romi.webster@tch.harvard.edu.

plines share information regarding the child and the circumstances of death. For example, autopsy findings indicative of child abuse, which were unavailable to the officers doing the death scene investigation, may shed new light on scene findings that were previously dismissed as insignificant. Inconsistent histories of the injury mechanism or discovery of the child may be revealed, highlighting a discrepancy between documented injuries and reported mechanism. Although originally developed to better identify maltreatment-related deaths, CDR is often used to facilitate prevention of child deaths more broadly, particularly injury-related deaths. Therefore, multi-agency multidisciplinary review has the potential to decrease misclassification of deaths, increase opportunities for effective intervention on behalf of surviving children, and prevent future deaths.⁴

The concept of conducting reviews of individual deaths dates back over 60 years with maternal mortality reviews. Maternal mortality reviews are conducted by multidisciplinary teams on the state level for the purpose of reducing pregnancy-related maternal mortality. Fetal and infant mortality review, started in 1988 with the goal of reducing infant mortality, consists of local in-depth review of selected fetal and infant deaths using nationally standardized review criteria. The first multidisciplinary multi-agency CDR team was formed in Los Angeles County in 1978.⁷ Unlike fetal and infant mortality review, CDR aims to review all deaths (or all deaths due to certain causes), and the criteria for review are set at the state or local level. Although multiple organizations have endorsed CDR, including the American Academy of Pediatrics⁸ and the American Bar Association,⁹ there are no standardized criteria for CDR and no national guidance to CDR programs.

In 1991, the U.S. Public Health Service (USPHS) endorsed CDR.¹⁰ The 1998–1999 annual progress review of the *Healthy People 2000* goals reported that 47 states and the District of Columbia had a CDR program.¹¹ Unfortunately, the USPHS report contained only a program count without additional information on scope or process. Based on personal experience with CDR programs in several states, we postulated that CDR programs were highly variable by state. However, after searching for a summary of state programs, no comprehensive summary of program attributes was found to exist. Documenting program variability is important because the lack of standardization will affect efforts to accurately describe the causes and circumstances of death among children at a national or regional level. In order to compare information across states or perform national level surveillance of child deaths using CDR data, states must be conducting reviews in a comparable way and collecting data using standardized definitions. This study was conducted in an effort to describe the current status of CDR in the United States and to assess

variability in program purpose, scope, organization, and process.

Methods

Study Population

A representative from the CDR program in each state and the District of Columbia was identified using the contact list maintained by the Interagency Council on Child Abuse and Neglect–National Child Fatality Review (J. Langstaff; Interagency Council on Child Abuse and Neglect–National Child Fatality Review, personal/written communication, 2000). An attempt was made to contact the person identified on the list as a “primary contact” in each state. When this primary contact could not be reached, usually because the person was no longer active in CDR in the state, a referral to the individual most knowledgeable about CDR in the state was requested. Once an appropriate person was identified and contacted, the nature of the study was explained and participation requested.

Data Collection

Data were collected in two phases. The first phase involved a 26-item questionnaire that was mailed, e-mailed, or faxed to the CDR representative who agreed to participate. The questionnaire was self-administered in most cases. However, if the participant was difficult to contact or expressed a preference to complete the questionnaire verbally, the questionnaire was completed via telephone (by RW or PS).

The second phase consisted of a follow-up telephone interview with the CDR representatives in states with a current CDR program. In the telephone interview, an attempt was made to clarify any omitted or confusing answers on the mail questionnaire, and then a 24-item survey was administered. Most of the interview questions were structured as multiple-choice or short-answer questions. Because of the rapidly developing nature of CDR programs, CDR representatives were asked to respond to all questions in the context of their current program.

In an effort to understand the CDR process in each state, respondents were asked to describe their review process in detail. The information provided allowed us to classify the timing of the review with respect to the investigation process. Reviews were classified as retrospective when respondents indicated that a review takes place only after the death certificate had been filed or any law enforcement investigation or criminal prosecution is complete. Reviews were classified as investigative in programs where a review takes place shortly after the death with the purpose of contributing information for determining the cause and manner of death or providing input for law enforcement or prosecution. Parallel reviews may take place prior to filing the death certificate or prior to a law enforcement investigation or prosecution being complete, but where the team does not specifically provide input into these processes.

In addition to the two survey instruments, supplemental documents were requested from respondents that might help us better understand the states’ CDR programs. Many states provided copies of data collection forms, annual reports, and/or legislation. All data were collected between December

15, 2000 and July 5, 2001. After completing content analysis of the text data from the telephone survey regarding review process, univariate and bivariate descriptive analyses were conducted using SPSS 10.0 for Windows (SPSS Inc., Chicago IL, 1999).

Institutional Review Board

This study was exempted from review by the Institutional Review Boards at Rhode Island Hospital and the University of Missouri Health Sciences Center.

Results

A 100% response rate was achieved. CDR representatives in all 50 states and the District of Columbia (hereafter referred to as a state for convenience) were contacted, agreed to participate, and returned the mail questionnaire. Two states reported that they currently had no program or CDR process. Follow-up phone interviews were completed for each state with a program. Results presented here are for the 49 states with active CDR at the time of data collection. Table 1 displays several key characteristics of CDR programs listed by state. The remaining results are presented in aggregate by CDR program purpose, scope, organization, and process variables.

Purpose of Review

Respondents were asked to rate each of five CDR purposes on a Likert scale. The following five purposes were stated on the questionnaire: (1) identify circumstances leading to cause of death, (2) provide suggestions for prevention of future child deaths, (3) review agency involvement and actions surrounding death, (4) collect data about child deaths for later analysis, and (5) assist in prosecution of child maltreatment fatalities. The results showed remarkable consistency in the stated purpose of child death review across the nation, with 94% of states rating "identifying circumstances of death" and "providing suggestions for prevention" as important (Table 2).

CDR Program Scope

Characteristics examined to assess CDR program scope included age of children covered, estimated percent of child population covered, and types of deaths reviewed. All but one state reviews deaths among children through at least age 17 years. The one exception reviews deaths among children from birth through age 15. Thirty-two respondents (65%) estimated that their coverage of deaths among children from birth through age 17 to be 99% to 100%. Only four states reported that their CDR process covers <50% of the child population within their states. Respondents' estimates of the number of child deaths reviewed annually by their CDR programs ranged from 11 to 2500.

Twenty-two states (46%) reported that they review child deaths from all causes; the remaining states perform selective review based on cause of death (Table 3). Six states (12%) review only maltreatment-related deaths. Of these six, four review suspected and confirmed maltreatment deaths and two review only confirmed maltreatment.

CDR Program Organization

CDR program organizational characteristics are listed in Table 4. Between 1990 and 2000, the number of CDR programs increased steadily, with the majority (53%) established between 1996 and 2000. CDR programs have been established by various mechanisms. Thirty-three states (67%) have legislation that enabled or mandated CDR. The remaining 16 states (33%) that operate without a legislation-imposed structure do so either on a voluntary basis (8 states) or under authorizing regulations or mandates (e.g., governor executive order). In 16 states (33%), the CDR program reports its findings to the legislature, and in 19 states (39%), it reports directly to the governor. Eighty-four percent of the CDR program representatives indicated that they publish an annual report.

CDR programs are currently not funded in 16 states. Although we did not specifically ask how these programs operated without funding, discussions with several state program officials revealed that unfunded programs often rely on in-kind donations of time from CDR participants and their sponsoring agencies. Respondents of the 33 funded programs were asked to indicate the adequacy of their funding, acknowledging that most programs could always use more money. Forty-five percent stated that current funding was inadequate to fulfill their mission. Funding for the majority of programs comes from the state (17 of 33). Federal agencies involved in funding include the Maternal and Child Health Bureau and the Department of Justice. Neither legislation nor funding was significantly associated with the percentage of the child population covered or with the types of deaths reviewed.

In most states, reviews are conducted at both the state and local levels (Table 4). The level of review was significantly associated with the total number of child deaths annually. States with fewer child deaths per year were more likely to have "state-only" level of review (analysis of variance [ANOVA]: $F=5.793$, $df=2$, $p=0.006$). Although exact CDR team composition varied, it was uniformly multidisciplinary in nature, and most teams at least included representatives from public health, law enforcement, social services, and clinical medicine (usually a medical examiner, pediatrician, or general practitioner). Examples of more unusual team members reported included insurance industry representatives, legislators, and tribal and armed forces representatives.

Table 1. Key CDR characteristics by state

| State | Year implemented ^a | CDR legislation ^b | Level of review ^c | Causes reviewed ^d | Collect data ^e | Currently funded ^f |
|----------------------------|-------------------------------|------------------------------|------------------------------|------------------------------|---------------------------|-------------------------------|
| Alabama | 1998 | Yes | Both | Selective | Yes | Yes |
| Alaska | 1997 | Yes | State | Selective | Yes | Yes |
| Arizona | 1994 | Yes | Both | All | Yes | Yes |
| Arkansas | 1998 | Yes | Both | All | Yes | Yes |
| California | 2000 | Yes | Local | Selective | Yes | Yes |
| Colorado | 1989 | No | Both | All | Yes | No |
| Connecticut | 1995 | Yes | State | Selective | Yes | No |
| Delaware | 1996 | Yes | Both | Selective | Yes | No |
| District of Columbia | 1993 | Yes | State | All | Yes | Yes |
| Florida | 1999 | Yes | Both | Selective | Yes | Yes |
| Georgia | 1993 | Yes | Both | Selective | Yes | Yes |
| Hawaii | 1999 | Yes | Local | All | Yes | Yes |
| Idaho | 1998 | No | State | Selective | Yes | Yes |
| Illinois | 1995 | Yes | Local | Selective | Yes | Yes |
| Indiana | 1999 | No | Both | Selective | Yes | Yes |
| Iowa | 1995 | Yes | State | All | Yes | Yes |
| Kansas | 1993 | Yes | State | All | Yes | No |
| Kentucky | 1997 | Yes | Both | Selective | Yes | No |
| Louisiana | 1993 | Yes | Both | Selective | Yes | Yes |
| Maine | 1993 | Yes | State | Selective | Yes | Yes |
| Maryland | 1999 | Yes | Both | Selective | Yes | No |
| Massachusetts ^g | — | — | — | — | — | — |
| Michigan | 1995 | Yes | Both | All | Yes | Yes |
| Minnesota | 1987 | Yes | Both | Selective | Yes | No |
| Mississippi | 1999 | No | Both | All | No | No |
| Missouri | 1992 | Yes | Local | All | Yes | Yes |
| Montana | 1994 | No | Both | All | Yes | Yes |
| Nebraska | 1994 | Yes | State | All | Yes | No |
| Nevada | 1992 | No | Both | All | Yes | No |
| New Hampshire | 1996 | No | State | Selective | Yes | No |
| New Jersey | 2000 | Yes | Both | All | No | Yes |
| New Mexico | 1998 | No | State | Selective | Yes | Yes |
| New York | 2000 | Yes | Local | Selective | Yes | Yes |
| North Carolina | 1992 | Yes | Both | Selective | Yes | Yes |
| North Dakota | 1996 | Yes | State | All | Yes | No |
| Ohio ^g | — | — | — | — | — | — |
| Oklahoma | 1991 | Yes | Both | All | Yes | Yes |
| Oregon | 1996 | Yes | Both | Selective | Yes | Yes |
| Pennsylvania | 1994 | No | Both | All | Yes | Yes |
| Rhode Island | 1998 | No | State | All | Yes | Yes |
| South Carolina | 1993 | Yes | Both | Selective | Yes | No |
| South Dakota | 1997 | No | Local | — | — | Yes |
| Tennessee | 1994 | Yes | Both | All | Yes | No |
| Texas | 1995 | Yes | Local | Selective | Yes | Yes |
| Utah | 1999 | No | State | All | Yes | Yes |
| Vermont | 1985 | No | Both | All | Yes | Yes |
| Virginia | 1996 | Yes | Both | Selective | Yes | No |
| Washington | 1999 | No | Local | Selective | Yes | Yes |
| West Virginia | 1998 | Yes | State | All | Yes | Yes |
| Wisconsin | 1999 | No | Both | Selective | Yes | Yes |
| Wyoming | 1998 | No | Both | Selective | Yes | No |

^aRespondents were asked to provide the year in which the *current* review process was implemented. Note that some states had established teams at the local or state level before the current program was established.

^bThis variable reflects the presence of mandating or enabling CDR legislation.

^cLevel of review was grouped so that "local" included reviews at the county, region, city, and judicial district level.

^dRespondents were asked to indicate whether they review all causes of death within their chosen age range, or whether they perform a more selective review based on cause of death.

^eRespondents were asked to indicate if cases were reviewed for data collection purposes as a part of the CDR program.

^fThis information was provided in response to the following question: "Is your CDR program funded today?"

^gThis state had no active program at the time of data collection.
CDR, child death review; —, missing data.

Table 2. Importance of stated purposes of child death review (*n*=49)

| Purpose of review (number missing) | Important ^a <i>n</i> (%) | Not important ^a <i>n</i> (%) |
|---|--|--|
| Identify circumstances leading to cause of death (3) | 46 (94) | 0 |
| Provide suggestions for prevention of future child deaths (2) | 46 (94) | 0 |
| Review agency involvement and actions surrounding death (3) | 39 (80) | 2 (4) |
| Collect data about child deaths for later analysis (4) | 38 (78) | 3 (6) |
| Assist in prosecution of child maltreatment fatalities (3) | 13 (27) | 23 (47) |

^aColumns do not add to 100% due to omission of neutral responses.

CDR Processes

Most (55%) CDR programs identify deaths for review through the coroner/medical examiner system, and the majority (59%) of reviews are retrospective (Table 5). Several respondents indicated that their CDR law forbids reviewing a death prior to completion of all investigations or prosecution. Consequently, the elapsed time between death and review was significantly related to whether reviews are parallel/investigative versus retrospective ($\chi^2=23.3$, $p<0.001$).

The relationship between state and local jurisdictions in the 27 states with a program on both levels varies. Of the 23 programs for which data were available, the state provides administration (e.g., centralized collection, storage, and management of data) and oversight (e.g., ensuring that all eligible deaths are reviewed) in 18 states. In seven programs, the state provides consultation/technical assistance to the local teams (e.g., training for law enforcement in child death scene investigation or coroners/medical examiners in the specifics of child autopsy). Responsibility for conducting reviews also varies. In 12 programs (12/23, 52%), the state-level team does not conduct any reviews (as reviews are conducted by local level teams only); in two programs, the state-level team reviews all the deaths; and in four programs, a state-level team reviews only those deaths occurring in local jurisdictions without a local team. Similarly, in states with reviews only on the local level,

the majority of programs are overseen by a state agency that provides administrative or technical assistance.

Respondents were asked whether they collected standardized data for aggregate analysis in addition to discussing information important to the classification and management of each individual death. If so, they were asked whether a standardized data collection form was used (Table 5). On average, programs with “state-only” level of review were collecting data on a significantly greater percentage of total child deaths than were state and local or local-only teams (ANOVA, $F=3.339$, $df=2$, $p=0.047$). Eleven states (22%) collect data on every child death. In general, the CDR teams meet fairly often, with 39% meeting at least monthly. In some states, teams in sparsely populated regions with infrequent child deaths meet only when a death occurs. However, in other areas, teams convene to review safety issues relevant to children in their community, even in the absence of any child deaths. This proactive ap-

Table 3. Scope of deaths reviewed (*n*=48)^a

| Deaths reviewed | Programs performing review <i>n</i> (%) |
|-------------------------------|---|
| All causes | 22 (46) |
| Selective review ^b | 26 (54) |
| Confirmed child maltreatment | 24 (96 ^c) |
| Suspected child maltreatment | 20 (80 ^c) |
| Suicide | 18 (72 ^c) |
| Homicide | 18 (72 ^c) |
| Unintentional injury | 17 (68 ^c) |
| Sudden infant death syndrome | 16 (64 ^c) |
| Natural/organic etiology | 2 (8 ^c) |

^aExcept where indicated.

^bIn states that do not review deaths from all causes. States may review deaths in more than one category.

^c*n*=25; specific data from one state with selective review is missing.

Table 4. CDR organizational characteristics (*n*=49)

| Organizational characteristics (number missing) | Frequency (%) |
|---|---------------|
| Year current CDR process implemented (0) | |
| <1990 | 3 (6) |
| 1990–1995 | 20 (41) |
| 1996–2000 | 26 (53) |
| CDR legislation (0) | |
| Yes | 33 (67) |
| No | 16 (33) |
| CDR program currently funded (0) | |
| Yes | 33 (67) |
| No | 16 (33) |
| Funding adequate (2) ^a | |
| Yes | 18 (55) |
| No | 13 (39) |
| Funding source (2) ^a | |
| Federal | 9 (27) |
| State | 17 (52) |
| Foundation/trust | 4 (12) |
| Other | 1 (3) |
| Level of review (0) | |
| State only | 14 (29) |
| Local only | 8 (16) |
| State and local | 27 (55) |

^aFor 33 programs with current funding. CDR, child death review.

Table 5. CDR process characteristics (*n*=49)

| Process characteristic (number missing) | Frequency (%) |
|--|------------------|
| How deaths are identified for review (1) | |
| Coroner/medical examiner system | 27 (55) |
| Death certificates/vital records | 18 (37) |
| Child protective services agency | 3 (6) |
| Type of review (0) | |
| Retrospective | 29 (59) |
| Parallel | 10 (20) |
| Investigative | 7 (14) |
| Investigative or retrospective | 3 (6) |
| Time elapsed between death and review (2) | |
| ≤3 months | 22 (45) |
| >3 months | 25 (51) |
| Collect data (1) | |
| Yes | 46 (94) |
| No | 2 (4) |
| Standardized data collection form ^a (1) | |
| Yes | 34 (74) |
| No | 11 (24) |

^aOf 46 programs that collect data.
CDR, child death review.

proach is conducive to primary prevention but may strain limited resources.

In addition to the results discussed above and presented in the corresponding tables, we explored possible relationships between legislation, types of deaths reviewed, total number of child deaths per year, funding, level of review, data collection, the timing of the review with respect to the investigation, as well as time elapsed between the death and review. None of these associations were statistically significant.

Discussion

This report is the first systematic assessment of CDR in the United States since 1992.⁷ The 100% response rate provides a solid foundation for this comprehensive assessment and description of the current status of CDR nationwide. Although detailed description of the intricacies of the CDR programs was impeded by the limited flexibility of the quantitative survey instruments to describe complex and diverse processes, this study provides important information on the progress in CDR over the past 10 years.

CDR programs are widespread in the United States and have become a mechanism for communities to respond in a positive way to the tragedy of a child's death. In the past decade, the number of states with CDR programs has grown from 21 to 48 states and the District of Columbia. These programs share commonalities in purpose and scope, but we also identified wide variation in program organization and process. For example, fully one third of the CDR programs operate without legislation. Potential advantages of having CDR legislation include standardization of process and data

collection, centralization and oversight, legal protection of CDR members from litigation, and confidentiality protocols. In addition, legislation may legitimize the CDR process and interventions at the local level, resulting in improved interagency sharing of information and funding. However, several states viewed legislation as a disadvantage, especially when it imposed restrictions or inflexible requirements on existing review processes.

Considering the prevalence and multiple national agency endorsement of CDR as a mechanism for understanding and preventing child deaths, it is remarkable that 59% of programs report no or inadequate funding. It is important to note that even with presumably sufficient funding, these programs exist largely through the efforts of professionals who volunteer their time to the review process either as individuals or with agency support. Many respondents indicated that further investment in the infrastructure of CDR would significantly improve programs by providing services not strictly within their mission or legislative mandate (e.g., personnel training, enhancing data quality, oversight, and follow-up).

Another important component that varies considerably across states is the performance of parallel/investigative versus retrospective reviews. Parallel and investigative reviews generally allow the CDR team to have timely and informed input into collection of data, determination of cause of death, protection of other siblings that may be at risk, and provision of other appropriate services. Because insufficient or inaccurate investigation data are a significant obstacle to meaningful review, some programs have integrated CDR into the investigative process. In one state, the chair of the CDR team is notified of a child death by law enforcement within 24 hours so that the CDR team is able to assist in and influence data collection, as well as activate a multi-agency response. Conversely, even though 94% of programs identify the clarification of circumstances as an important purpose, the majority of states perform retrospective reviews. With the reviews occurring more than 3 months after the child's death, the opportunities for improved data collection and secondary prevention are compromised at best. In some states, teams are trying to mitigate the negative effects of mandated retrospective review by conducting proactive education of law enforcement, coroners, and health professionals.

Why this wide variation in CDR organization and process in the United States? We believe it is because the growth of CDR is the result of grassroots support and championing efforts by committed individuals at the local and state levels with limited national leadership. These findings document the variability in CDR program components across states. The variability in program organization and process begs the question: What works best? Unfortunately, this important question cannot be answered because there is no uniform

system for CDR⁸ and no national criteria by which program structure and impact might be judged. Consequently, there is no way to compare programs across states and no standards or criteria on which to judge program impact. Only one state, Georgia, has formally evaluated its CDR process¹²; its 1996 process evaluation illustrated the complexities involved in documenting program effectiveness.

In spite of the challenge involved in establishing national standards and criteria for CDR programs, we believe this is a critical next step in our ability to document the value of CDR programs and evaluate their effectiveness. As the federal public health agency, the Centers for Disease Control and Prevention (CDC) is in an ideal position to provide leadership for this project. The CDC should work in concert with state CDR program directors and the newly funded Keeping Kids Alive National Resource Center for CDR to develop national standards and criteria for CDR program structure and process. Additional potential partners in this much needed effort include the American Academy of Pediatrics, Maternal and Child Health Bureau, and the State and Territorial Injury Prevention Directors Association.

Despite notable prevention efforts, injury continues to be the leading cause of death among children aged 1 to 18 years. Because CDR provides in-depth review of the circumstances of child injury deaths, there is increasing interest in using state CDR programs as an infrastructure for national child death surveillance (C. Barber, Harvard Injury Control Research Center, personal/written communication, 2001), specifically to guide injury prevention.¹³ However, before state-based CDR data can be used for national surveillance, a set of program criteria, core data elements, and standardization of certain processes must take place. National leadership and support are crucial for the systematic development of a network of state CDR programs and standardization of data definition and collection. With respect to using CDR program data for surveillance and to inform injury prevention efforts, national leadership should also be provided by the CDC in concert with a national organization representing state public health departments, such as the State and Territorial Injury Prevention Directors Association.¹⁴ Recent relevant CDC projects include providing funding for the development of child maltreatment surveillance systems in five states and development of a CDR module for the proposed National Violent Death Reporting System. While these steps will bolster and standardize child maltreatment and violent injury surveillance, a broader focus to include unintentional injuries is warranted.

We believe that the use of CDR program data for injury prevention at the national level has tremendous potential. However, before national surveillance is possible, CDR programs must be strengthened and evalu-

ated, and standard processes and criteria must be implemented. Importantly, without coordinated national leadership, future progress toward enhancing CDR will stall and the full potential of CDR data will not be realized.

We are grateful to Paul Matz, MD, Roderick King, MD, MPH, and Dalia Batista, MD, for their assistance in study design and conceptual input; Patrick Vivier, MD, for assistance with design and analysis; and Scott Laney for assistance with data collection. Special thanks to Lloyd Potter, PhD, and Stephen Wirtz, PhD, for reviewing an earlier draft of this manuscript. PGS was funded in part by a Career Development Award from the National Institute of Child Health and Human Development (5K08HD1377-01).

References

1. National Center for Health Statistics. 10 Leading causes of death, United States: 1998, all races, both sexes. Atlanta GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Office of Statistics and Programming, 2000 Available at: <http://webapp.cdc.gov/sasweb/ncipc/leadcaus.html>. Accessed on March 26, 2001.
2. McClain PW, Sacks JJ, Froehle RG, Ewigman BG. Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatrics* 1993;91:338-43.
3. U.S. Advisory Board on Child Abuse and Neglect. A nation's shame: fatal child abuse and neglect in the United States. Washington DC: U.S. Department of Health and Human Services, 1995.
4. Herman-Giddens ME, Brown G, Verbiest S, et al. Underascertainment of child abuse mortality in the United States. *JAMA* 1999;282:463-7.
5. National Clearinghouse on Child Abuse and Neglect Information. Highlights from child maltreatment 1999. Washington DC: U.S. Department of Health and Human Services, 1999 Available at: www.calib.com/nccan/ch/pubs/factsheets/canstats.cfm. Accessed on October 2, 2001.
6. Ewigman B, Kivlahan C, Land G. The Missouri Child Fatality Study: underreporting of maltreatment fatalities among children younger than five years of age, 1983 through 1986. *Pediatrics* 1993;91:330-7.
7. Durfee MJ, Gellert GA, Tilton-Durfee D. Origins and clinical relevance of child death review teams. *JAMA* 1992;267:3172-5.
8. Kairys SW, Alexander RC, Block RW, et al. American Academy of Pediatrics. Committee on Child Abuse and Neglect and Committee on Community Health Services. Investigation and review of unexpected infant and child deaths. *Pediatrics* 1999;104:1158-60.
9. Anderson TL, Wells SJ. Data collection for child fatalities: existing efforts and proposed guidelines. Chicago: Child Maltreatment Fatalities Project, American Bar Association, Center on Children and the Law, and American Academy of Pediatrics, 1991.
10. U.S. Department of Health and Human Services. Healthy people 2000: national health promotion and disease prevention objectives. Washington DC: U.S. Department of Health and Human Services, Public Health Service, 1991.
11. National Center for Health Statistics. Healthy people 2000 review, 1998-99. Hyattsville MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics, 1999.
12. Kellermann AL, Thomas W, Henry G, Waid M, Fajman NN, Carter J. The best of intentions: an evaluation of the child fatality review process in Georgia. Atlanta GA: Center for Injury Control, Rollins School of Public Health, Emory University; The Applied Research Center, Georgia State University, 1996. Available at: www.sph.emory.edu/CIC/gafatality.html. Accessed on October 2, 2001.
13. Schackner R, Timmel D. A national child fatality review database: is it possible now? Paper presented at 128th annual meeting and exposition of American Public Health Association, Boston MA, November 12-16, 2000.
14. State and Territorial Injury Prevention Directors Association. STIPDA. Marietta GA: State and Territorial Injury Prevention Directors Association, 2000. Available at: www.stipda.org/. Accessed on September 19, 2001.

APPENDIX M: Glossary

State of Washington Department of Health CHILD DEATH REVIEW GLOSSARY

| | |
|--|--|
| ABANDONMENT | The act of a parent or caretaker leaving a child for an excessive period of time without adequate supervision or provision for the child's needs. The age of the child is an important factor in determining whether the child has been abandoned. |
| ABDOMINAL DISTENTION | Swelling of the abdomen (the area located between the chest and pelvis), which may be caused by internal injury, bowel blockage or malnutrition. (3) |
| ABNORMAL | Deviating from the standard; not average, typical or usual |
| ABRASION | A wound in which either skin or mucous membranes have been scraped off. (2) |
| ACCIDENTAL DEATH | Death caused by unintended or unexpected means where abuse or neglect is not considered causative. (13) |
| ACCOUNTABILITY | The measurable extent to which an organization, individual or the general public keeps the promises made to the people served. Most often this involves providing assurance to someone or some organization that the expected action occurred |
| ACUTE | In medicine, refers to a health effect that is brief, intense and short term (as compared to chronic. (2) |
| ACUTE PANCREATITIS | An acute inflammation of the pancreas (the organ in the body which produces and secretes the enzymes which aid in digestion). Symptoms include severe abdominal pains, nausea and fever. In children, trauma should be considered as a possible cause. (3) |
| ADDICTION | Over-dependence on the intake of certain substances (such as alcohol, nicotine and other drugs) or performing certain acts, such as smoking. Inability to overcome a habit or behavior pattern. |
| ADJUDICATION HEARING | See FACT FINDING HEARING |
| ADOPTION | A legal process that vests all legal rights and responsibilities of the parenthood in persons other than the child's biological or previously adoptive parent. |
| ANEMIA | Any condition in which the number of red blood cells (carriers of oxygen throughout the body) are less than normal. (6) |
| ANOREXIA | Lack or loss of appetite for food. (6) |
| ANOREXIA NERVOSA | A personality disorder manifested by an extreme aversion to food. It usually, but not exclusively, occurs in young women. May include bingeing and purging (Bulimia). (6) |
| ANOXIA | A total lack of oxygen (2) |
| ANTERIOR | In human anatomy, the front surface of the body. (3) |
| ANTICIPATED DEATH | A death resulting from a diagnosed terminal illness or other debilitating or deteriorating illness or condition. |
| APNEA | Cessation of respiration. A respiratory pause is abnormal if it is 20 seconds or longer or associated with a change in color or causes the heart to beat more slowly (bradycardia). (1) |
| APPEAL | In legal terminology, resort to a superior (appellate) court or administrative agency to review the decision of an inferior court (trial or lower appellate) or administrative agency. |
| ANTISOCIAL PERSONALITY (OR SOCIOPATHIC PERSONALITY) | A personality disorder characterized by poor social relationships and an inability to conform to cultural, ethical and social norms. The lack of a superego or conscience. (6) |

| | |
|------------------------------------|--|
| ARRAIGNMENT | One of the first steps in the criminal process in which the defendant is formally charged with an offense (i.e., given a copy of the complaint) and informed of her/his constitutional rights (e.g., to plead not guilty, be indicted, have a jury trial, be appointed counsel if indigent). (10) |
| ASPHYXIA | Death caused by being deprived of oxygen. Can be caused by strangulation, suffocation, choking or smothering. |
| ASSAULT | The attempt to inflict bodily injury on another person, with unlawful force and the apparent ability to inflict the bodily injury unless stopped. Assault may be either a crime or a tort (a private or civil wrong). (6) |
| ASSESSMENT | All activities involved in the concept of community diagnosis: surveillance, identifying needs, analyzing the causes of problems, collecting and interpreting data, monitoring and forecasting trends, and evaluation of outcomes. |
| ATROPHY | Wasting away of flesh, tissue, cell or organ. (2) |
| AUTISM | A syndrome appearing in childhood with symptoms of self-absorption, inaccessibility, aloneness, inability to relate to others, highly repetitive play and language disorders. The cause is unknown. (2) |
| AUTOPSY | The dissection of a dead body for the purpose of inquiring into the cause of death. Also, post mortem examination to determine the cause or nature of a disease. An autopsy is normally required by statute for violent, unexpected, sudden or unexplained deaths. (13) |
| AVITAMINOSIS | A condition caused by the lack of one or more essential vitamins, which may be caused by lack of vitamins in the diet or by the body's inability to use the vitamins because of disease. |
| AVULSION | A forcible separation or tearing away of a body part or tissue. (2) |
| BABY GRAM | (Slang) One or two x-rays taken in order to see all of a baby's body at one or two angles (often inadequate). |
| BASILAR SKULL FRACTURE | A fracture to the base of the skull which will often result in a spinal fluid leaking from the nose or the ear. (3) |
| BATTERED CHILD SYNDROME | A term introduced in 1962 by C. Henry Kempe, M.D., describing a combination of physical and other indicators that a child's internal and external injuries result from acts committed by a parent or caretaker. In some states, Battered Child Syndrome has been judicially recognized as an acceptable medical diagnosis. (3) |
| BEST INTERESTS OF THE CHILD | A standard used by child welfare agencies and courts meaning that the action being undertaken or ordered best maintains a child's emotional growth, health and stability, and physical care (RCW 26.09.002). (12) |
| BILATERAL | Occurring on, or pertaining to, two sides. (2) |
| BIRTH PARENT | A parent to whom a child is born. Also call "biological" or "natural" parent. |
| BLUNT FORCE TRAUMA | Injury caused by force from a blunt object (such objects may include hands and feet). Includes abrasions, bruises, contusions and lacerations. |
| BOARD CERTIFIED | A physician who has completed residency training and has passed an official medical board approved examination to be listed as a specialist in a particular field. |

| | |
|--|---|
| BONE SCAN | A nuclear medicine study that can assist in the diagnosis of early or minimal fractures, especially in children under two years of age where bones have not ossified. (3) |
| BRAIN CONCUSSION | A violent jarring or shaking injury to the brain. After a mild concussion there may be a brief loss of consciousness with a headache on awakening. A severe concussion may cause lengthy unconsciousness and disruption of certain vital functions of the brainstem, as breathing. (8) |
| BRAIN STEM | Portion of the brain connecting the cerebrum and cerebellum to the spinal cord. (2) |
| BRUISE | An injury that does not break the skin but causes ruptures of small underlying vessels with resultant discoloration of tissues. Synonymous with contusion, ecchymosis. Organs can also be bruised, e.g., brain, kidney. (6) Petechiae – very small bruises caused by broken capillaries Purpura – petechiae occurring in groups or a small bruise up to one centimeter in diameter Ecchymosis – bruise larger than one centimeter in diameter |
| BURN | A wound resulting from the application of heat, cold, electricity or chemicals to the body, classified in terms of the degree of damage: <u>1st degree</u> - superficial injury limited to the epidermis (outer skin layer). <u>2nd degree</u> - injury through the epidermis and dermis, typically causing the formation of blisters. <u>3rd degree</u> - destruction of epidermis and dermis, including nerve fibers. (3) |
| CALCIFICATION | Process by which organic tissue becomes hardened by the deposition of lime salts within its substance, e.g., the formation of bone. Seen through x-ray, the amount of calcium deposited indicates the degree of healing of a broken bone or the location of previous healed fractures. (3) |
| CALLUS | A small cartilage fragment that forms a tissue, or shell, around the site of a fracture and gradually fuses with underlying bone as the fracture heals. This is visible on x-ray about a week after the injury. Also, a thickening of skin at locations of pressure or friction. (3) |
| CALVARIA (CALVARIUM) | The upper dome-like portion of the skull, composed of the superior portions of the frontal, parietal and occipital bones. |
| CAMIS | Children's Administration Management Information System; a computerized database and documentation system used by all Washington DSHS Children's Administration staff, including those in the Division of Children and Family Services and those in the Division of Licensed Resources. (9) |
| CAPTA | See Child Abuse Prevention and Treatment Act |
| CARTILAGE | Hard connective tissue that is not bone. In the fetus and growing child, cartilage may be the forerunner of bone before calcium is deposited to form bone. (3) |
| CARETAKER | In child welfare, a person responsible for a child's health or welfare. This may be the child's parent or guardian, another person within the child's own home or relative in a relative's home, foster care home or residential institution. |
| CASA (COURT APPOINTED SPECIAL ADVOCATE) | A non-lawyer who represents the best interest of a child in a child welfare proceeding. See Guardian Ad Litem |
| CASE | In child welfare, refers to both the process of a child and family through the child welfare agency and to the process of the child and family through court. |

| | |
|--|---|
| CASE MANAGEMENT | A systematic approach where emphasis is placed on the systems in which a client must function. Case management requires identification and coordination of the multiple services required by a client. (6) |
| CASE PLAN | In child welfare. Based on the initial risk and family assessments, the social worker guides the family to identify and prioritize immediate and longer-term goals. Services are identified to deal with any deficiencies in family functioning. A case plan is required whether the child remains in the home and the plan is voluntary or the child is in foster care and the plan court ordered. (9) |
| CASE WORKER | The staff member of a child welfare agency who is responsible for working with a child or family. |
| C.A.T. SCAN | (Computerized Axial Tomography) A radiological study using x-rays translated by computer to show body cross sections. |
| CAUSE OF DEATH | The disease and/or injury, listed on the death certificate, which starts the lethal chain of events (brief or prolonged) leading to death. (11) |
| CELLULITIS | Inflammation of the skin and connective tissue. (2) |
| CEREBRAL | Pertaining to the brain. (2) |
| CEREBRAL EDEMA | Swelling of the brain due to accumulation of watery material. |
| CHILD/MINOR | A person less than eighteen years of age. |
| CHILD ABUSE AND NEGLECT, AND EXPLOITATION (CA/N) | Abusive, neglectful, or exploitive acts defined in RCW 26.44.020 include: (a) Inflicting physical injury on a child by other than accidental means, causing death, disfigurement, skin bruising, impairment of physical or emotional health, or loss or impairment of any bodily function. (b) Creating a substantial risk of physical harm to such child's bodily functioning. (c) Committing or allowing to be committed any sexual offense against such child as defined in the criminal code or intentionally touching, either directly or through the clothing, the genitals, anus, or breasts of a child for other than hygiene or child care purposes. (d) Committing acts which are cruel or inhumane regardless of observable injury. Such acts may include, but are not limited to, instances of extreme discipline demonstrating a disregard of a child's pain and/or mental suffering. (e) Assaulting or criminally mistreating a child as defined by the criminal code. (f) Failing to provide food, shelter, clothing, supervision, or health care necessary to a child's health or safety. (g) Engaging in actions or omissions resulting in injury to, or creating a substantial risk to the physical or mental health or development of a child. (h) Failing to take reasonable steps to prevent the occurrence of (a) - (g). (WAC 388-15-130). (12) |
| CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) | An act introduced and promoted in Congress by then U.S. Senator Walter Mondale and signed into law on January 31, 1974. The Act emphasizes multidisciplinary approaches to child abuse and neglect. (6) |
| CHILD DEATH REVIEW (CDR) aka CHILD FATALITY REVIEW aka CHILD MORTALITY REVIEW | A systematic comprehensive review of factors that contribute to deaths of children. The purpose is to reduce preventable deaths of children by identifying problems leading to such deaths, collecting and reporting standardized information, improving interagency communication through case and issues review, and developing appropriate prevention strategies. The review is a coordinated, multi-disciplinary process involving individuals from community agencies relevant to the health and welfare of children of all ages. Statutory Authority: RCW 70.05.170 (1991). |

| | |
|--|---|
| CHILD DEVELOPMENT | Pattern of sequential stages of interrelated physical, psychological, and social development in the process of maturation from infancy and total dependence to adulthood and relative independence. (6) |
| CHILD NEGLECT | An injury to a child caused by the omission of necessary acts including failure to provide food, healthcare, shelter or safety. (See Child Abuse) |
| CHILD PROTECTIVE SERVICES (CPS) | Services provided by the DSHS on behalf of children who are reported to be abused, neglected, or exploited or who are threatened with harm through abusive, neglectful, or exploitive acts by: (a) Parent, legal custodian, or persons serving in loco parentis; or (b) Persons licensed or certified under chapter 74.15 RCW ; or (c) Persons included within those categories of alleged perpetrators and subject to CPS investigation, as specified by department manual provisions or policy directives. (WAC 388-15-130). (12) |
| CHILD SEXUAL ABUSE | The employment, use, persuasion, inducement, enticement or coercion of any child to engage in or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution or other form of sexual exploitation of children or incest with children. |
| CHOKING | When the upper airway is blocked by a foreign object. |
| CHRONIC | In medicine, developing slowly and persisting for a long period of time. Compare "acute". (2) |
| CIRCUMSTANCES OF DEATH | Identification of details surrounding an incident of death in order to identify contributing factors. This is one of the tasks of the CDR team and requires breadth of material not necessarily available in the death certificate or coroner/medical examiner report. |
| CIVIL COURT | Courts that are established for the adjudication of controversies between individual parties, or the ascertainment, enforcement, and redress of private rights. The court that hears child welfare cases is a civil court. Contrast "criminal court". (13) |
| CLOTTING FACTOR | Material in the blood that causes it to coagulate or clot. Deficiencies in clotting factors can cause profuse internal bleeding or bruising, as in the disease hemophilia. Bruises or bleeding caused by deficiencies in the clotting factor may be mistaken for abuse. (7) |
| COAGULATION | The process of clotting. The body's process of healing itself when blood is released from an injured vessel. (6) |
| COAGULATION STUDIES | Blood tests done to diagnose or rule out diseases of clotting factors. (6) |
| COINING | A Southeast Asian folk remedy in which the edge of a coin is repeatedly rubbed over the body, generally the upper torso, windpipe, and inner arm. The result is a series of reddish to purple vertical bruises resembling strap marks, which vary in depth and severity. The bruises are believed to be an indicator for the evil spirits of a disease to exit the body. (7) |
| COLON | The part of the intestine that connects the small bowel with the rectum. (2) |
| COLPOSCOPE | Optical instrument for low power magnification and photography of the external genitalia as well as the vagina and cervix. Used for detection of sexual injuries as well as ano-rectal injuries. (3) |

| | |
|----------------------------|---|
| COMMISSIONER | A person appointed by a court in certain cases to hear testimony and make reports that, if approved by the court, become the decision of the court. In some states, commissioners may hear child welfare court cases. |
| COMMON LAW | In the law, the system of jurisprudence (the form of law) which developed in England and came to American colonies during colonization. Common law is derived and developed from the decisions of judges. |
| COMPETENT INTENT | The desire to cause an event to happen by someone with the ability to form that intent (some say a child under the age of 8 does not have the ability to form competent intent). |
| CONCUSSION | An injury to the brain caused by a violent jarring or shaking or a blow to the brain. After a mild concussion there may be a brief loss of consciousness with a headache on awakening. A severe concussion may cause lengthy unconsciousness and disruption of breathing or other vital functions of the brainstem. |
| CONFIDENTIALITY | Information and reports used in the CDR process (vital records, social services, death investigations, medical) can only be disclosed outside the CDR by the agency providing the data and according to their legal requirements. Only non-identifying data will be collected in the CDR database and data will be published in aggregate form only. |
| CONGENITAL | Those mental or physical traits, malformations, disease, etc., that are present at birth. May be hereditary or due to some influence during gestation. (7) |
| CONTUSION | See BRUISE |
| CORONER | An official whose duty it is to investigate sudden, suspicious, or violent death to determine the cause. May or may not be a physician. In some communities the coroner has been replaced by the medical examiner who is a physician. (14) |
| CORPORAL PUNISHMENT | Physical punishment inflicted directly upon the body. Some parents believe that corporal punishment is the only way to discipline children, and some child development specialists believe that almost all parents must occasionally resort to corporal punishment to discipline or train children. Other parents and professionals believe that corporal punishment is never advisable. (6) |
| CORTEX | The outer layer of an organ or other body structure. (2) |
| COSTAL CARTILAGE | Cartilage that attaches the ribs to the sternum or to other cartilage. (5) |
| CRANIUM | The skeleton of the head (the skull). (2) |
| CRIME SCENE | The physical site where a crime may have occurred. |
| CRIMINAL COURT | Courts that are charged with the administration of the criminal laws, and the punishment of wrongs to the public. The court that hears cases involving the crime of child abuse are criminal courts. Contrast "civil court". (13) |
| CRISIS INTERVENTION | The purposeful activities and involvement of a helping person which provide a rapid problem solving response at the point that another person or family is caught in acute, disabling distress due to situational events. (6) |
| CUPPING | A folk remedy in which an alcohol-soaked material is ignited in a small cup or jar. After the flame is extinguished, the cup is placed over the skin and the resulting suction forces the tissue into the mouth of the cup. The cup is left in place for approximately twenty minutes. Cupping results in a 2-inch circular, non-raised, ecchymotic bum. Wounds usually are produced in symmetrical, vertical rows, in clusters of two and four on the right and left side of the chest, abdomen and back, or in smaller groupings on the forehead. (6) |

| | |
|----------------------------------|---|
| CUSTODY | In law, the right to care and control of a child and the duty to provide that child's food, clothing, shelter, ordinary medical care, education and discipline. Parents are the natural custodians of their child. However, a court may grant temporary custody to someone other than a parent, pending further action or review by the court. |
| CUTANEOUS | Pertaining to the skin. (2) |
| CYANOSIS | Purple or bluish discoloration of the skin and mucous membranes, caused by a lack of oxygen in the blood. (3) |
| DEATH | The cessation of life, manifested in people by a loss of heart beat, absence of spontaneous breathing and the permanent loss of brain function; loss of life. |
| DEATH CERTIFICATE | Official document noting the cause and manner of death. |
| DEATH INVESTIGATION | Mandated by state law (RCW 68.50.010) in the case of deaths attributable to sudden and unexpected events. Investigation activities include scene/circumstance evaluation and autopsy/toxicological examination to determine the cause and manner of death. Every county has one of the following, determined by population whose office is responsible for death investigation: elected Prosecutor/Coroner, elected Coroner, or appointed Medical Examiner. |
| DEATH SCENE INVESTIGATION | An attempt by a person functioning in an official capacity to gather information at the site where a fatal illness, injury or event occurred, for the purpose of determining the cause and circumstances of a death. (3) |
| DEFENDANT | In civil proceedings, the party responding to the complaint brought by the plaintiff. In criminal proceedings, the person tried for a crime; also called the accused. (10) |
| DEHYDRATION | Condition that results from excessive loss of fluid from body tissues. May occur after any condition in which there is a rapid loss of body fluids, including fever, diarrhea, or vomiting. Particular concern in infants and young children. (2) |
| DEPRESSION | A mental state of depressed mood characterized by extreme feelings of sadness, despair, hopelessness and discouragement. Depressions ranges from normal feelings of "the blues" through dysthemia to major depression. (2) |
| DERMIS | Inner layer of skin. (5) |
| DIAPHYSIS | The shaft (long, thin part) of a long bone between the two flared ends. (2) |
| DIFFERENTIAL DIAGNOSIS | The determination of which of two or more diseases or conditions a patient is suffering from, by systematically comparing and contrasting their clinical findings. For example, osteogenesis imperfecta is a differential diagnosis for child abuse. (2) |
| DISCIPLINE | Behavior that educates and corrects or punishes. (6) |
| DISLOCATION | Displacement of a bone from a joint. Displacement may accompany a fracture. Minor forms of dislocations "subluxations." (6) |
| DISPOSITION HEARING | In a child welfare court case, a court hearing that determines the nature of the guidance, treatment or rehabilitation (case plan) needed by the child. (2) |

| | |
|--|--|
| DISSOCIATION | In psychology, the separation of thought or feeling from consciousness, e.g. when a sex abuse victim "pulls away" from the cognitive and emotional experience of the abuse. "Multiple Personality Disorder" is a severe and rare outcome of dissociation. (6) |
| DISTAL | The parts of the body, or portions of a bone, that are furthest - or more distant - from the trunk, e.g. the hands or feet. Compare "proximal". (5) |
| DUE PROCESS OF LAW | The right of persons under the 5th and 14th Amendments to the U.S. Constitution to procedural and substantive fairness in situations in which the government would deprive the person of life, liberty or property. (10) |
| DURA MATER | The outermost, toughest, and most fibrous of the three membrane (meninges) covering the brain and the spinal cord. (2) |
| EARLY NOTIFICATION OF CHILDHOOD DEATH SYSTEM (ENCD) | WA State DOH Center For Health Statistics program whereby county registrars transmit death certificate information within one week of a child's death. The resulting data base provides more timely notice of child deaths to state and local health programs, including Child Death Review. |
| ECCHYMOSIS | A small hemorrhagic spot, larger than a petechia, in the skin or mucous membrane forming a nonelevated, rounded or irregular blue or purplish patch (bruises). Plural: ecchymoses. (2) |
| EDEMA | Swelling caused by an excess pooling of fluid in body tissues. (3) |
| EGG SHELL FRACTURE | Fracture of the skull that looks like a broken egg on x-ray examination. (7) |
| ELIGIBLE DEATH | Death meets the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when attended by a physician or any manner that is suspicious or unusual. |
| EMERGENCY MEDICAL SERVICES | The complete chain of human physical resources that provide patient care in cases of sudden illness or injury. |
| EMERGENCY MEDICAL TECHNICIAN (EMT) | <p>A provider of emergency care who has received formal training and is appropriately certified. Three types of emergency medical technicians:</p> <p><u>EMT-basic</u> - An EMT with the ability to administer oxygen and initiate defibrillation who is not allowed to perform any type of <u>invasive care</u>.</p> <p><u>EMT-intermediate</u> - An EMT who has passed specific training programs in order to provide some level of advanced life support. For example, the initiation of intravenous lines and administration of some medications. In some states, this level includes those EMTs who are given the title of cardiac technician or cardiac rescue technician.</p> <p><u>EMT-paramedic</u> - A person who has successfully completed paramedic training including or equal to the Department of Transportation national standard paramedic curriculum and has received appropriate certification. EMT- paramedics can generally perform relatively invasive field care including insertion of endotracheal tubes, initiation of intravenous lines, administration of medications, and cardiac defibrillation. (15)</p> |
| EMOTIONAL MALTREATMENT | In child welfare, passive or active patterned, non-nurturing behavior by a parent or caretaker that negatively affects or handicaps a child emotionally, psychologically, physically, intellectually, socially or developmentally. (3) |
| ENCOPRESIS | In continence of feces not due to organic defect or illness. Considered by some a mental disorder if it occurs in a child older than four. (2) |
| ENURESIS | Involuntary discharge of urine after the age at which urinary control should have been achieved. (2) |

ENVIRONMENTAL

Pertaining to all of the many factors, including physical and psychological factors, which affect the life of a person. (8)

EPIDEMIOLOGY

The science concerned with the study of the factors determining and influencing the frequency, distribution, and causes of disease, injury, and other health-related events in a defined human population for the purpose of establishing programs to prevent and control their development and spread. (2)

EPIDERMIS

The outermost layer of skin. (2)

EPIPHYSIS

The rounded ends of a long bone. (3)

EVIDENCE

In law, something that makes another thing evident or tends to prove a fact at issue to be true. All the means by which any alleged matter of fact, the truth of which is submitted to investigation, is established or disproved.

Circumstantial - Evidence of facts or circumstance from which the existence or non-existence of an issue may be inferred.

Direct - Evidence that directly proves the fact, without an inference or presumption and which by itself, if true, conclusively establishes that fact.

Hearsay - An out-of-court statement intended to prove the truth of the matter being asserted. For example, "John said Mary struck the baby" is hearsay if the statement is intended to prove that Mary struck the baby. Hearsay evidence is usually excluded because it is considered unreliable and the person making the original statement cannot be cross-examined.

Opinion - Although witnesses are ordinarily not permitted to testify as to their beliefs or opinions, being restricted instead to reporting what they actually saw or heard, a witness can give opinions if qualified as an expert.

Physical - Any tangible piece of proof, e.g., a document, X-ray, photograph or weapon. Physical evidence usually must be authenticated by a witness who testifies to the connection of the evidence with other facts in the case.

Prima facie - Evidence that will suffice as proof of the fact in issue until its effect is overcome by other evidence. (13)

EXAMINATION

The questioning of a witness. Types of examination:

Direct - The first questioning or examination of a witness by the party on whose behalf the witness is called.

Cross - The questioning of a witness by the party opposed to the one who produced the witness.

Redirect - Questioning of a witness by the direct examiner subsequent to the cross-examination of the witness.

Recross - Questioning of a witness by a cross-examiner subsequent to a redirect examination of the witness. (13)

EXPERT WITNESS

In the law, a witness who has special knowledge of the subject about which the witness will testify. The witness may qualify as an expert through experience, training or education. Only an expert witness may testify in the form of an opinion. (6)

EXPUNGEMENT

Destruction of records. In the law, expungement may be ordered by a court after a specified number of years or when the juvenile, parent or defendant applies for expungement and shows that his/her conduct has improved. In child welfare, expungement also means the removal from the Central Registry of certain reports of abuse or neglect. (6)

EXTREMITY

Portion of the body that is not part of the trunk: arms, legs, hands, feet. (5)

FACT FINDING HEARING

A hearing in juvenile court required by RCW 13.34.110 at which the court considers a petition for dependency and determines if the facts support a finding that the child is dependent and in need of protection. (9)

| | |
|---|---|
| FAILURE TO THRIVE | A medical condition seen in young children where the child does not gain weight. It may be associated with a decrease in the rate of growth or in a growth rate that is significantly below the norm. The cause may be organic (e.g., cystic fibrosis, heart disease) or non-organic, such as poor nutrition, inadequate food intake, or inappropriate formula preparation. (6) |
| FAMILY DYNAMICS | Interrelationships between and among individual family members. The evaluation of family dynamics is an important factor in the identification, diagnosis and treatment of child abuse and neglect. (6) |
| FAMILY DYSFUNCTION | Ineffective functioning of the family as a unit or of individual family members in their family roles because of the physical, mental or situational problems of one or more family members. (6) |
| FAMILY PRESERVATION SERVICES | In-home or community-based services drawing on the strengths of the family and its individual members while addressing family needs to strengthen and keep the family together where possible and may include: (a) Respite care of children to provide temporary relief for parents and other caregivers; (b) Services designed to improve parenting skills with respect to such matters as child development, family budgeting, coping with stress, health, safety, and nutrition; and (c) Services designed to promote the well-being of children and families, increase the strength and stability of families, increase parents' confidence and competence in their parenting abilities, promote a safe, stable, and supportive family environment for children, and otherwise enhance children's development. (RCW 74.14C.010). (9) |
| FAMILY RECONCILIATION SERVICES | Services designed to develop skills and supports within families to resolve problems related to at-risk youth, children in need of services, or family conflicts and may include but are not limited to referral to services for suicide prevention, psychiatric or other medical care, or psychological, mental health, drug or alcohol treatment, welfare, legal, educational, or other social services, as appropriate to the needs of the child and the family. Family reconciliation services may also include training in parenting, conflict management, and dispute resolution skills. (RCW 13.32A.040). (9) |
| FAMILY REUNIFICATION SERVICES | Services which support the principle that the preferred permanency plan for a child in foster care is the return to the family if the child's safety can be ensured. |
| FATALITY | Loss of life. See DEATH. |
| FELONY | Generally, any criminal offense for which the penalty is imprisonment for more than one year. Murder, rape and armed robbery are crimes which are considered felonies. See "misdemeanor". (6) |
| FELONY DEATH | See HOMICIDE. |
| FETAL ALCOHOL SYNDROME | A congenital syndrome caused by intrauterine exposure to alcohol. Characteristics include intra and extrauterine growth retardation, microcephaly (small head) and mental retardation. (6) |
| FETAL DEATH | (Common) Death of pregnancy after approximately 20 weeks. |
| FETAL DEATH CERTIFICATE | Official document noting the death of a fetus (note—does not include a space for manner of death.) |
| FETAL HOMICIDE | (Legal) The death of a viable fetus caused by competent intent. |
| FETAL AND INFANT MORTALITY REVIEW (FIMR) | Model developed by National College of Obstetrics and Gynecology which specifies procedures to be followed when investigating and reviewing the death of a fetus or infant up to one year of age. Not currently in practice in Washington State. |

| | |
|-----------------------------|--|
| FONTANELLE | The two soft areas ("soft spots") on the head of an infant where the bones are not yet joined. One soft spot disappears at about two months and the other at about eighteen months of age. A "bulging fontanelle" may indicate increased pressure in the skull. (3) |
| FORENSIC | Having to do with the study of criminal acts. |
| FORENSIC PATHOLOGIST | A pathologist with training in criminal pathology. |
| FOSTER CARE | Placement for children under dependency court jurisdiction. Includes continuous 24-hour care and supportive services provided for a child while the child needs substitute care outside of the child's family. Foster care may be provided in either a licensed foster family home or group care facility. (WAC 388-70-012). (9) |
| FRACTURE | <p>Any break or crack in bone or cartilage:</p> <p><u>basilar skull</u> – a fracture to the base of the skull which will often result in spinal fluid leaking from the nose or ear</p> <p><u>bucket handle tear</u> - total fracture of a long bone so that it is floating loose.</p> <p><u>chip</u> - A small piece of bone that is separated from the main body of a bone; sometimes referred to as an "avulsion fracture."</p> <p><u>comminuted fracture</u>- A bone is broken into a number of pieces.</p> <p><u>compound fracture</u> - a broken bone which protrudes through the skin.</p> <p><u>egg shell</u> – a fracture of the skull that looks like a broken egg on an x-ray</p> <p><u>greenstick fracture</u> – the bone is bent and there is an incomplete fracture in the convex side of the curve. Common among young children.</p> <p><u>incomplete</u> – the line of the fracture does not include the entire bone</p> <p><u>occult fracture</u> - a fracture that is hidden or not visible on x-rays.</p> <p><u>pathologic fracture</u> - a fracture occurring at a site weakened by preexisting disease, as seen in osteogenesis imperfecta, tumors or Gaucher's Disease.</p> <p><u>simple fracture</u> - a break in a bone without displacement of bone pieces.</p> <p><u>spiral fracture</u> - a break in a bone which is spiral shape, resulting from twisting of the extremity.</p> <p><u>torus</u> - a folding, bulging or buckling break. (3)</p> |
| FRENULUM (OR FRENUM) | The bridge of skin which connects the lips to the gums and the tongue to the floor of the mouth. (3) |
| GAUCHER'S DISEASE | A rare, familial disease in infants which may cause fractures. Gaucher's Disease is a differential diagnoses for child abuse. (6) |
| GENITALIA | The external reproductive organs. (6) |
| GLUTEAL | Relating to the buttocks. (6) |
| GROSS EXAMINATION | In medicine, a physical examination without the aid of radiologic instruments or surgical entry. (6) |
| GROUP HOME | A type of foster care in which care is provided in a small group setting. (9) |
| GUARDIAN | An adult who is legally responsible for a child. A guardian has almost all the rights and powers of a parent, but the legal relationship is subject to termination and change. Guardian may also have physical custody of the child. (6) |

GUARDIAN AD LITEM

A lawyer or non-lawyer who represents the best interest of a child in a child welfare court proceeding. Unless otherwise directed by the court, the duties of the guardian *ad litem* include but are not limited to the following:

- (a) To represent and be an advocate for the best interests of the child;
- (b) To collect relevant information about the child's situation;
- (c) To monitor all court orders for compliance and to bring to the court's attention any change in circumstances that may require a modification of the court's order; and
- (d) To report to the court information on the legal status of a child's membership in any Indian tribe or band. RCW 13.34.105. (12)

HEMATEMESIS

Vomiting of bright red blood, often resulting from internal injury. (3)

HEMATOMA

Swelling caused by the accumulation of blood in body tissues. (3)

HEMATURIA

Blood in the urine. (2)

HEMOPHILIA

An inherited disorder of the blood in which there is a defect in the ability to clot, resulting in a tendency to hemorrhage. (3)

HEMOPTYSIS

Spitting or coughing up blood originating in the lungs or bronchial tubes.(3)

HEMORRHAGE

Bleeding; it is sometimes used interchangeably with hematoma.

Ecchymosis - bruise larger than 1 centimeter in diameter

Intra-abdominal - Within the abdomen

Intracerebral - Within the brain

Intracranial - Within the skull

Intradermal - Within the skin, i.e., bruising is bleeding within the skin. Bruises are common injuries in abused children, and are usually classified by size.

Intramural hematoma of the duodenum - A hematoma occurring in the wall of the duodenum. Occurs only from trauma.

Petechiae - very small bruises caused by broken capillaries.

Purpura – petechiae occurring in groups or a small bruise up to 1 centimeter in diameter.

Retinal – within the inner lining of the eye, hallmark of whiplash and Shaken Baby Syndrome (3)

HEMOSTAIIIS SCREEN

Laboratory study performed to determine whether or not a child has a bleeding or bruising tendency. (3)

HEPATIC

Pertaining to the liver. (2)

HOMICIDE

Any killing of a human being by another human being. Homicide does not necessarily constitute a crime. An unlawful homicide, or a homicide resulting from an unlawful act, may constitute murder or manslaughter:

Murder - The unlawful killing of a human being with malice aforethought. Malice aforethought requires premeditated intent.

Felony Murder - The unintentional killing of a human being during the commission of a felony

Manslaughter - An unlawful killing of a human being without malice aforethought.

Voluntary Manslaughter - An intentional killing committed under circumstances which, although they do not justify the homicide, mitigate it. For example, a killing in the heat of passion caused by the deceased's provocation may be considered voluntary manslaughter. Traditionally, this was applied to a husband's killing his wife after learning she had been unfaithful.

Involuntary Manslaughter - Criminally negligent homicide, such as a death resulting from the negligent operation of a motor vehicle. (10)

| | |
|--|--|
| HOSPITAL SHOPPING | The use by a person or family of different medical facilities so that each individual medical facility's sole contact with the person or family is a single presenting injury. (6) |
| HYDROCEPHALUS | "Water on the brain." In infants, it occurs when the outflow tract of the brain ventricles narrows or becomes obstructed, and spinal fluid accumulates in the ventricles. This increases the intracranial pressure resulting in destruction of normal brain tissue. A shunt can be placed into the ventricle to drain away excess spinal fluid and lower pressure. (3) |
| HYPERACTIVE | More active than normal. The term has become synonymous with Attention Deficit Disorder with Hyperactivity ("ADDH" or "ADHD"), which is characterized by inattention, impulsivity and hyperactivity. Generally, this life-long condition can be controlled using behavioral techniques and, when necessary, medication (Ritalin, Cylert, Dexadrine, Imipramine). Hyperactive children are at increased risk for injury because of their impulsivity. (3) |
| HYPEREMIA | An excess of blood in a part of the body causing reddening of the skin- it disappears when pressure is applied. (5) |
| HYPERPIGMENTATION | Abnormally increased pigmentation (coloring) of the skin. (2) |
| HYPERTHERMIA | Abnormally high body temperature. (2) |
| HYPHEMA | Hemorrhage into the anterior chamber of the eye, often appearing as a blood-shot eye. A blow to the head or violent shaking are two possible causes. (3) |
| HYPOACTIVE | Less active than normal. (2) |
| HYPOTHERMIA | Abnormally low body temperature. (2) |
| HYPOTHALAMUS | The portion of the brain which controls and integrates functions such as general regulation of water balance, body temperature, sleep, food intake and the development of secondary sex characteristics. (6) |
| HYPOVITAMINOSIS | A condition caused by a deficiency of one or more essential vitamins. (6) |
| ICD-10 | International Classification of Diseases, 10th edition is an international system for classifying (coding) medical diagnoses and is used for many purposes. A death is given an ICD-10 classification by the county registrar, based on information contained in the death certificate issued by the medical examiner/coroner. The ICD-10 provides a classification of deaths by internal cause (disease) or external cause (event). ICD-10 E codes are used when there is an external (E) event, such as a fall, which is the underlying cause of death. External causes are also grouped into Intentional, Unintentional and Other External Event. |
| IDEALIZATION | In psychology, attributing exaggerated positive qualities to self or other, e.g. a child may idolize an absent or abusive parent. (6) |
| IDENTIFICATION | In psychology, increasing feelings of worth by identifying oneself with a person or institution of illustrious standing. (6) |
| IDENTIFICATION WITH THE AGGRESSOR | In psychology, a defense mechanism consisting of imitation of the aggressor. (6) |
| ILEUM | The last section of the small intestine which connects it to the colon; the appendix is near the end of the ileum. (3) |
| IMPASSIVITY | In psychology, state of not feeling or showing emotion. (6) |

| | |
|--|---|
| IMPETIGO | A highly contagious superficial bacterial infection of the skin which occurs primarily in infants and young children. The disease is characterized by red blisters that rapidly become pustules. The blisters are frequently located around the nose and mouth. May be confused with cigarette bums. (3) |
| INCEST | Sexual intercourse between persons who are closely related by blood. While incest between parent and child or siblings is almost universally forbidden, various cultures may extend the boundaries to prohibit intercourse with other relatives. In the US, the prohibition against incest is specified by state laws as well as by cultural tradition. States usually define incest as marriage or sexual relationships between relatives who are closer than second or sometimes even more distant, cousins. While incest and sexual abuse are often thought to be synonymous, incest is only one type of sexual abuse. |
| INCIDENCE | In epidemiology, the extent to which a problem occurs in a given population. (6) |
| INDIAN CHILD WELFARE ACT (ICWA) | A federal law which specifies the manner in which child welfare agencies and child welfare courts must handle cases involving Native American and Alaska Native children. (6) |
| INFANT | A child under one year of age. (3) |
| INFANTICIDE | The killing of one or more infants. (6) |
| INJURY | Refers to any force whether it be physical, chemical, thermal or electrical that results in harm or death. |
| INSTITUTIONAL REVIEW BOARD | Under F federal guidelines, the groups designated by an institution to review research and practice methodologies relevant to protections to prevent harm and protect confidentiality particularly as they relate to human subjects. |
| INTENTIONAL INJURY DEATH | Public health term used to define death caused by another with the intent to cause harm. |
| INTENT | Desire to cause to happen. |
| INTRAOCULAR | Within the eye. (2) |
| INTRAVENOUS | Referring to the inside of a vein. For example, an intravenous injection is an injection into a vein. (5) |
| JEJUNUM | Middle section of the small intestine connecting duodenum and ileum. (2) |
| JUDGEMENT | In law, the court's determination of a controversy before it; a final decision. (6) |
| JURISDICTION | In law, a court's authority over the subject matter, the person, and the rendering of a particular order or judgment. (6) |
| KINSHIP CARE (RELATIVE PLACEMENT) | Residential caregiving provided to children by nonparental relatives. Kinship care may be full-time or part-time, temporary or permanent and may be initiated by private family agreement or under the custodial supervision of a child welfare agency. |
| LACERATION | A torn or jagged wound causing a splitting or tearing in the external skin surface in addition to the deep tissue. Wounds caused by stabbing are not lacerations. (5) |
| LANGUAGE DELAY | A situation in which a child's language abilities are considerably poorer than the abilities of most children of the same age. (6) |
| LATERAL | Occurring on, or pertaining to, one side. (5) |

| | |
|--|--|
| LESION | Any injury to any part of the body from any cause that results in damage or loss of structure or function of the body tissue involved. A lesion may be caused by poison, infection, dysfunction or violence, and may be either accidental or intentional. (6) |
| LETHARGY | Abnormal drowsiness or stupor; a condition of indifference. (2) |
| LEUKEMIA | A progressive, malignant disease of blood forming organs. Children suffering from leukemia may present petechiae or bleeding which should be considered in the differential diagnosis of children who bruise easily. (5) |
| LOCAL HEALTH JURISDICTION (LHJ) | The county or regional local government entity charged with the provision of public health services. The 35 LHJs in Washington State have legislative authority to convene multi-disciplinary teams to review deaths of children in their jurisdiction. RCW 70.05.170. 1993. (12) |
| LONG BONES | Bones of arms (ulna, radius, humerus) and legs (femur, tibia, fibula). (5) |
| MALNUTRITION | A condition caused by inadequate nourishment. |
| MANDATED REPORTERS | In child welfare, persons, designated by state law, who are legally responsible for reporting suspected child abuse and neglect to the mandated agency. Mandated reporters vary according to state law, but they are primarily professionals, such as doctors, nurses, school personnel, and social workers who have frequent contact with children and families. (6) |
| MANDIBLE | The bone of the lower jaw. (6) |
| MANNER OF DEATH | The legal classification of death, whether it be natural, suicide, homicide, accident, undetermined, pending. (11) |
| MECHANISM OF DEATH | The physical reason for a death (e.g., head trauma caused brain swelling which caused decreased brain function which caused the heart and/or lungs to stop functioning). |
| MEDIAL | Towards the middle or mid-line. (3) |
| MEDICAL EXAMINER | A certified forensic pathologist appointed to investigate cases of sudden, violent or suspicious death. |
| MEDICAL EXAMINER / CORONER REVIEW | "...all deceased persons who come to their death suddenly, when in apparent good health, without medical attendants, within the thirty-six hours preceding death; or where the circumstances of death indicate death was caused by unnatural or unlawful means; or where death occurs under suspicious circumstances; or where coroner's autopsy or postmortem or coroner's inquest is to be held..."(RCW 68.50.010). (12) |
| MEDICAL NEGLECT | Generally, the repeated failure by parents or caretakers to seek necessary medical care or comply with recommendations from medical professionals for the treatment of a child's medical condition. (6) |
| MENKES KINKY HAIR SYNDROME | A rare, genetic metabolic disorder which blocks absorption of copper in the gastrointestinal system, causing brittle bones and eventually death. It may be mistaken for child abuse. (7) |
| MESENTERY | Membranes which cover abdominal organs and attach the bowel to the abdominal wall. The mesentery may be injured in interabdominal trauma or inflamed, as with peritonitis. (6) |
| METAPHYSIS | The area of bone between the epiphysis (extremity) and diaphysis (shaft) which flares out at the end of long bones. It contains the growth zone of the bone. (3) |

| | |
|---|---|
| MISDEMEANOR | Criminal offenses that are less severe than felonies and generally punishable by lesser fines or by jail terms which do not exceed one year. Compare "felony". (6, 11) |
| MONGOLIAN SPOT | A type of birthmark which appears most frequently on a child's lower back or buttocks. These darkly pigmented areas usually fade by age 5. Most often seen in dark skinned peoples. They sometimes are confused with bruises. (3) |
| MUNCHAUSEN SYNDROME BY PROXY | A pattern of abuse in which the perpetrator, usually a parent, will fabricate medical histories, inflict physical findings, alter laboratory specimens and induce disorders in a child to give the appearance that the child is ill. (3) |
| NATIONAL CRIME INFORMATION CENTER (NCIC) | Criminal justice information system operated by the Federal Bureau of Investigation in Washington, D.C. (3) |
| NATURAL CAUSE | Death resulting from inherent, existing conditions. Natural causes include congenital anomalies, disease, other medical causes and SIDS. |
| NEGLIGENCE | In the law, doing something that a person of ordinary prudence would not do, or the failure to do something that a person of ordinary prudence would do, under given circumstances. (6) |
| NEONATAL | Pertaining to the first 4 weeks of life. (2) |
| NEUROLOGIC SEQUELAE | A diseased condition of the nervous system resulting from previous disease. In abused children, the condition may result from previous abuse. (6) |
| NON-INTENTIONAL INJURY DEATH OCCIPITAL | Public health term to replace accidental death. Back of the head. (3) |
| OSSIFICATION | The process during which immature or new bone or cartilage is converted into bone. (2) |
| OSTEOGENESIS IMPERFECTA | A genetic condition which causes bones to be brittle and prone to fracture. It may be mistaken for child abuse. (6) |
| OSTEOMYELITIS | Inflammation of bone caused by a bacterial organism. (6) |
| PARALYSIS | Complete or partial loss of functioning, usually involving motor function in a part of the body. |
| PARAMEDIC | See EMERGENCY MEDICAL TECHNICIAN |
| PARENS PATRIAE | "Parent of the country." Refers to the role of the state as sovereign and the guardian of persons under legal disability. It is through its power of parens patriae that a state investigates possible child abuse and neglect and places a child in foster care. (6) |
| PASSIVE | In psychology, not reacting visibly to something that might be expected to produce manifestations of an emotion or feeling. (6) |
| PATHOGNOMONIC | Specifically distinctive or characteristic of a disease or pathologic condition; a sign or symptom on which a diagnosis can be made. (2) |
| PERINATAL | The period of time from around the twenty-eighth week of gestation through the first seven days after delivery (2) |
| PERINEUM | Region of the body between the anus and the genitals. (5) |

**PERIOSTEAL ELEVATION
(HEMORRHAGE)**

The tearing away or lifting up of the bone's covering, from the hemorrhaging that occurs when a bone is broken or there has been bleeding under the periosteum. This is not necessarily indicative of child abuse as it can be due to leukemia or infiltrative disease such as tumors or inflammation. It may be present at birth from a difficult delivery. (6)

PERIOSTEUM

The outer covering of bones essential for bone formation and healing. (5)

PERIODIC REVIEW

In child welfare, the six-month review of cases of children in out-of-home care required by Public Law 96-272. Per WA State RCW 13.70.003: Provide periodic review of cases involving substitute care of children in a manner that complies with case review requirements and time lines imposed by federal laws pertaining to child welfare services. (9)

PERITONEUM

The lining of the abdomen cavity. (6)

PERITONITIS

Inflammation of the peritoneum. (2)

PERJURY

Knowingly and willfully giving false testimony under oath. (6)

PERMANENCY PLAN

In child welfare, a plan for implementing the most permanent long-term living situation possible for a child, consistent with the child's best interests. This plan specifies where and with whom a foster care child shall live, and the proposed legal relationship between the child and the permanent caretaker or caretakers. WA State RCW 13.34.145: A permanency plan shall be developed no later than sixty days from the time the supervising agency assumes responsibility for providing services, including placing the child, or at the time of a hearing under [RCW 13.34.130](#), whichever occurs first. The permanency planning process continues until a permanency planning goal is achieved or dependency is dismissed. The planning process shall include reasonable efforts to return the child to the parent's home. (9)

**PERMANENCY PLANNING
HEARING**

In a child welfare court case, the annual hearing in which the court reviews the child's case to ensure that the permanency plan being implemented is in the child's best interest. WA State: RCW 13.34.145: a) For children ten and under, a permanency planning hearing shall be held in all cases where the child has remained in out-of-home care for at least nine months and an adoption decree ~~((or))~~, guardianship order, or permanent custody order has not previously been entered. The hearing shall take place no later than twelve months following commencement of the current placement episode.

(b) For children over ten, a permanency planning hearing shall be held in all cases where the child has remained in out-of-home care for at least fifteen months and an adoption decree ~~((or))~~, guardianship order, or permanent custody order has not previously been entered. The hearing shall take place no later than eighteen months following commencement of the current placement episode. (9)

PERPETRATOR

In child welfare, a person(s) who committed an act that resulted in the death of a child.

PETECHIAE

Pinpoint, non-raised, perfectly round, purplish red spots caused by intradermal or submucous hemorrhage. (2)

PETITION

In law, a formal, written request to the court that it do something. The petition is a pleading that begins a court case. It contains the facts and circumstances upon which a court is asked to provide certain relief as well as the relief being sought.

PIA MATER

The innermost of the three membranes (meninges) covering the brain and spinal cord. (2)

PLAINTIFF

In a civil case, the person who files a lawsuit.

| | |
|------------------------------|---|
| PLEADINGS | In law, formal allegations of the claims and defenses raised by the parties to a court case. |
| POSTERIOR | Towards the back. In human anatomy, the back surface of the body. (3) |
| POSTPARTUM DEPRESSION | Depression which may occur after child birth. (6) |
| PREMATURE INFANT | An infant born after 27 weeks of gestation but before full term and, arbitrarily, an infant weighing 2.2-2.5 pounds at birth. (2) |
| PRENATAL | Existing or occurring before birth, with reference to the fetus. (2) |
| PREVENTABLE DEATH | A death in which, with retrospective analysis, it is determined that a reasonable intervention (e.g. medical, educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined as taking into consideration the condition, circumstances, or resources available. |
| PREVENTION | <p>The keeping of something (such as injury or disease) from happening.</p> <p><u>Primary</u>: the first level of care, designed to prevent the occurrence of disease or injury and promote health.</p> <p><u>Secondary</u>: the second level of care, based on the earliest possible identification of disease or injury so that it can be more readily treated or managed and adverse sequelae can be prevented</p> <p><u>Tertiary</u>: the third level of care, concerned with promotion of independent function and prevention of further disease or injury- related deterioration.</p> |
| PROBABLE CAUSE | In law, a requisite element of a valid search and seizure or acts and of an arrest, which consists of the existence of circumstances within one's knowledge that is sufficient to warrant the belief that a crime has been committed (in the context of an arrest) or that property subject to seizure is at a designated location (in the context of a search and seizure). The issue of whether probable cause exists depends on the independent judgment of a "detached magistrate". (10) |
| PROSECUTION | The act of pursuing a law suit or criminal trial; also, the party initiating a criminal suit. (10) |
| PROTOCOL | A standardized, written procedure for a particular process that is agreed to and followed by all participants in that process. |
| PROXIMAL | Refers to those parts of the body, or portion of a bone, that are closest to the trunk or to the point of origin, e.g., the shoulder or thigh. Compare "distal". (5) |
| PSYCHOSIS | In psychology, a mental disorder causing gross impairment of a person's mental capacity, affecting response and capacity to recognize reality. |
| PSYCHOTIC | In psychology, gross impairment of reality testing, often with delusions, hallucinations, etc. (6) |
| PUBLIC HEALTH FOCUS | Emphasis on population-based prevention which protects entire communities or populations through a highly collaborative approach to assessment and prevention planning. |
| PURPURA | See HEMORRHAGE, INTRADERMAL |
| RADIOLUCENT | In medicine, a part of a body or object which permits the passage of x-rays without leaving a shadow on the film. Soft tissues are radiolucent, bones are not. (6) |
| RAREFACTION | Loss of density. On an x-ray, an area of bone which appears lighter than normal is in a state of rarefaction indicating a loss of calcium. (3) |

| | |
|--|---|
| RATIONALIZATION | In psychology, attempting to prove that one's behavior is "rational" and justifiable, and thus worthy of self and social approval. (6) |
| REACTION FORMATION | In psychology, the substitution of behavior, thoughts or feelings which are diametrically opposed to the person's own unacceptable ones. For example, a parent feels guilty about the lack of bonding with the child and instead overindulges the child. (6) |
| REASONABLE EFFORTS | In child welfare, the ordinary diligence and care by a family and children's service agency to identify child protection problems and provide services to solve those problems so as to prevent out-of-home placements or promote family reunification. (3) |
| RECURRENT OTITIS MEDIA | Repeated inflammation of the middle ear. It is a leading cause of hearing loss in children. (6) |
| REGRESSION | In psychology, retreating to an earlier developmental level involving less mature responses and, usually, a lower level of aspiration. (6) |
| RELATIVE PLACEMENT (KINSHIP CARE) | Unless there is reasonable cause to believe that the safety or welfare of the child would be jeopardized or that the efforts to reunite the parent and child will be hindered, priority placement for a child in shelter care shall be with any person described in RCW 74.15.020(2)(a). The person must be willing and available to care for the child and be able to meet any special needs of the child. If a child is not initially placed with a relative pursuant to this section, the supervising agency shall make an effort within available resources to place the child with a relative on the next business day. The supervising agency shall document its effort to place the child with a relative pursuant to this section. Nothing within this subsection establishes an entitlement to services or a right to a particular placement. Relative placement is now required at shelter care unless it cannot be accomplished. Fictive kin are those that fit the definition in subsection (v) for Indian children, and are not actually related to the child by blood or by marriage. The State of Washington has a written agreement with the Tribes to honor the use of fictive kin as placement resources for Indian children. (9) |
| REPRESSION | In psychology, a defense mechanism in which the person is unable to remember disturbing feelings, thoughts, or experiences. (6) |
| RETINAL HEMORRHAGE | Bleeding into the retina of the eye, hallmark of Shaken Baby Syndrome. (3) |
| RICKETS | Condition of delayed maturation of the bones caused by a Vitamin D deficiency. May be seen with severe malnutrition, hypoparathyroidism and renal disease. (3) |
| RISK ASSESSMENT | The structured gathering and evaluation of information needed to predict or determine the presence, level and type of risk(s) to the child's current and future safety and welfare; a philosophy of practice in CPS; the conclusion that a child is likely or unlikely to be abused/neglected in the future. As relevant factors change, risk assessment must therefore be conducted over the life of a case.(4) |
| RUBELLA | An infectious viral disease with particular effects on fetuses or newborn infants. One of the early manifestations may be petechiae or easy bruising. There may be associated bone lesions that may be confused with child abuse. (6) |
| RUPTURED | The break of an organ or other soft part, as in ruptured blood vessel. (5) |
| SACRAL AREA | Lower part of the back. (3) |

| | |
|---|--|
| SCAPULA | The flat, triangular bone in the back of the shoulder; the shoulder blade. (6) |
| SCAR | The dense, fibrous tissue that is left behind by the healing of injured tissue. (7) |
| SCLERA | The rough white outer layer of the eyeball. One may see hemorrhage of the sclera as a result of a blow to the eye. (6) |
| SEARCH WARRANT | An order issued by a judge, directing certain law enforcement officers to conduct a search of specified premises for specified things or persons, and to bring them before the court. Use of a search warrant is required by the Fourth and Fourteenth Amendments to the U.S. Constitution. (10) |
| SECONDARY INFECTION | Infection by a microorganism following an infection by another kind of microorganism. (6) |
| SEIZURES | Involuntary muscular contractions and relaxations originating from a "short circuit" of the central nervous system. Seizures vary in pattern, length and intensity. Causes include fever, tumors, injuries or epilepsy. (3) |
| SEQUELAE | The after-effects of an injury or disease process. In child abuse, this term usually refers to the psychological or physical outcomes which result from being abuse or neglected. (6) |
| SEROLOGY | The study of blood serum for evidence of infection. |
| SEXUAL ABUSE | As defined by the federal Child Abuse and Adoption Assistance Act, (A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or, (B) the rape, molestation, prostitution, or other form of sexual exploitation of children or incest with children. WAC 388-15-130 (c): Committing or allowing to be committed any sexual offense against such child as defined in the criminal code or intentionally touching, either directly or through the clothing, the genitals, anus, or breasts of a child for other than hygiene or child care purposes. (12) |
| SEXUALLY TRANSMITTED DISEASE (STD) | Disease transmitted by sexual contact, including chlamydia, trichomonas, gonorrhea, syphilis, hepatitis B, and HIV. The presence of an STD in a child is an indicator of possible sexual abuse. However some STD's are passed to the fetus during pregnancy or at birth. (3) |
| SHAKEN BABY SYNDROME | Injury to an infant or child resulting from violent, repetitive shaking. Pathognomonic findings include intracranial hemorrhages, retinal hemorrhages and no cutaneous manifestations of injury. Survivors are frequently left with profound neurologic sequelae, e.g., blindness, deafness, mental retardation, cerebral palsy, seizures and death. (3) |
| SHAKEN IMPACT SYNDROME | Characterization of head injuries to a young child occurring with both shaking and impact. Different from Shaken Baby Syndrome, which does not include impact. |
| SHELTER CARE HEARING | A hearing held by the child welfare court that determines the need for emergency out-of-home placement for a child who is alleged to have been maltreated. WA State RCW 13.34.060: The child and his or her parent, guardian, or custodian shall be informed that they have a right to a shelter care hearing. The court shall hold a shelter care hearing within seventy-two hours after the child is taken into custody, excluding Saturdays, Sundays, and holidays. If a parent, guardian, or legal custodian desires to waive the shelter care hearing, the court shall determine, on the record and with the parties present, that such waiver is knowing and voluntary. (9) |

| | |
|---------------------------|---|
| SIDS | See SUDDEN INFANT DEATH SYNDROME |
| SKELETAL SURVEY | A series of x-rays taken of all the bones of the body. (5) |
| SMOTHERING | Specifically refers to asphyxiation of the nose and mouth usually by a hand or soft object. Mechanical asphyxia resulting from external pressure on the body preventing chest movement and breathing. |
| SOCIAL ISOLATION | The limited interaction and contact of many abusing or neglecting parents with relatives, neighbors, friends, or community resources. Social isolation can perpetuate a basic lack of trust, which hinders both the identification and treatment of child abuse and neglect. (6) |
| SOCIAL WORKER | Social workers have primary responsibility to coordinate the case planning efforts of all persons working on behalf of the child. This includes helping to develop goals and the means to their achievement with the parents in order to strengthen the family. Social Workers were previously called Case Workers in the State of Washington. The name of the class changed to recognize the fact that Social Workers are professionals and should be treated as such. (9) |
| SOMATIZATION | In psychology, a pathology in which a person becomes preoccupied with physical symptoms disproportionate to any actual physical disturbance. May be seen in victims of sexual abuse. (6) |
| SPLITTING | In psychology, a defense mechanism in which a person views self or others as all good or bad, failing to integrate the positive and the negative qualities of self and others into cohesive images. Often the person alternately idealizes and devalues the same person (e.g. the client who is either defiant or compliant with the worker with little apparent conviction). (6) |
| SPOONING/FINGERING | A folk remedy from Southeast Asia for relief of pain. The middle knuckle of the index finger or a spoon is firmly rubbed along the surface of the skin in any area of an ill person's body, especially along the spine, behind the knees, in the bends of both arms, and on the chest from just above the nipple to mid-clavicle. If a raised line appears, no further treatment is necessary. (7) |
| SPRAIN | Injury to joint muscles with no tearing of ligaments or tendons. (3) |
| STANDARDS OF PROOF | <p>The amount of probability necessary for a court to render a decision regarding the evidence presented to it. There are three different standards of proof:</p> <p>Beyond a reasonable doubt - the amount of probability required to find a criminal defendant guilty. The proof must be so conclusive and complete that the ordinary person could not reasonably deny it.</p> <p>Clear, cogent, and convincing - an amount of probability less than beyond a reasonable doubt but more than probable cause. It is used in some civil cases, including termination of parental rights cases. The proof must produce a firm belief of truth to the trier of fact.</p> <p>Preponderance of evidence - the amount of proof required in most civil cases, including child welfare dependency cases (except for termination of parental rights proceedings). The proof must be more likely than not.</p> <p>Reasonable Cause to Believe – a statement from a credible witness that the ca/n incident occurred. Sufficient for Shelter Care. (13)</p> |
| STATE CDR TEAM | Multi-disciplinary team of professionals with specialized knowledge in the areas of public health, medicine, law enforcement, mental health, social services and social work. State Team members will, at the invitation of a local CDR team, participate in the review of child deaths where their particular expertise is needed. (As of July 2003 the Washington State CDR Team was disbanded when state funding was discontinued.) |

| | |
|---|--|
| STATUTE | A law passed by a legislative body. For federal laws, a statute is a law passed by Congress. |
| STERNUM | The bone that runs down the front part of the chest; the breast bone. (5) |
| SUBARACHNOID BLEEDING | Bleeding that occurs between the pia and the arachnoid membranes of the central nervous system. (3) |
| SUBCUTANEOUS | Beneath the skin. (5) |
| SUBDURAL HEMATOMA | Bleeding between the internal lining of the skull and the brain. (3) |
| SUBGALEAL | The inner lining of the scalp; a site of hemorrhage frequently secondary to hair pulling. (6) |
| SUBPOENA | In law, a command to appear at a certain time and place, on a certain date, and to give testimony on a certain matter. (6) |
| SUDDEN INFANT DEATH SYNDROME (SIDS) | A diagnosis of exclusion made when there is the sudden and unexpected death of an infant under one year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death and review of the case history. It is not caused by abuse or neglect. (1) |
| SUFFOCATION | Asphyxia caused by a general deprivation of oxygen either from obstruction of external airways or lack of breathable gas in the environment. |
| SUICIDE | Death of self, caused with intent. |
| SUMMONS | In law, a document used to commence a civil action or special proceeding. A summons is issued by a court to the sheriff (or other proper officer), requiring the sheriff to notify the person named that an action has been commenced against the person and that the person is required to appear on a day named and answer the complaint. (13) |
| SYMMETRICAL | Similar in shape, size, structure and position. (5) |
| SYNDROME | In medicine, a group of signs and symptoms that occur together and are typical of a particular disorder or disease. (8) |
| TEMPORAL | Referring to the side of the head. (3) |
| TERMINATION OF PARENTAL RIGHTS ("TPR") | A legal process that severs the legal relationship between parents and child and vests that authority in the child welfare agency. The TPR order places the child in the guardianship of the child welfare agency and gives the agency the right to consent to adoption or long-term care short of adoption. RCW 13.34.180: A petition seeking termination of a parent and child relationship may be filed in juvenile court by any party to the dependency proceedings concerning that child. (9) |
| TESTIMONY | Evidence given by a competent witness under oath or affirmation, as distinguished from evidence derived from written and other sources. (6) |
| THORAX | Chest area, encompassing the heart, lungs and ribs. (5) |
| TORSION | Twisting, as of a limb. (5) |
| TRACTION | Drawing or pulling of a limb, as in setting a bone. (5) |

| | |
|---|---|
| TRAUMA | In medicine, an injury or wound brought about by an outside force. Usually trauma means injury by violence, but it may also apply to the wound caused by any surgical procedure. Trauma may be caused unintentionally or, as in a case of physical abuse, intentionally. Trauma is also a term applied to physiological discomfort or symptoms resulting from an emotional shock or painful experience. (6) |
| UNEXPECTED DEATH | A death not resulting from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated (natural death). Also known as Unnatural Death. |
| UNEXPLAINED DEATH | Death where the mode of death is not clear. Also known as Undetermined Death. |
| UNINTENTIONAL VS. INTENTIONAL INJURY | ICD-10 categorizes injury/death as intentional (homicide, suicide) or unintentional (mva, drowning, choking,/suffocation/fire). These are frequently used terms in WA State Injury statistics. |
| VASCULAR | Pertaining to or containing blood vessels. (6) |
| VENEREAL DISEASE | See SEXUALLY TRANSMITTED DISEASE |
| VENUE | Related to the locality of the court or courts which possess jurisdiction (6) |
| VESICLES | Blisters that contain fluid. (5) |
| VIABLE FETUS | A fetus that would be able to live outside the uterus if born as defined by experts. |
| VISCERAL | Pertaining to the internal organs. (5) |
| VITAL SIGNS | Blood pressure, heart rate, respiratory rate and temperature. (7) |
| VITREOUS | The material which is enclosed in the major portion of the eye. This is normally clear. With an eye injury one may have a vitreous hemorrhage. (6) |
| WELT | Minor damage to the skin or to the blood vessels directly underneath the skin caused by a blow or a cut. Does not involve bleeding. (8) |
| WOUND PATTERN | Wounds that are close together, similar in size and shape, and inflicted in the same area of the body. A patterned injury is one where the pattern is created by the instrument of injury (hand mark, cord, cigarette, etc.) A pattern of injuries is a series of injuries in various stages of healing. |



CHILD DEATH REVIEW DATA COLLECTION FORM



Check case category

- ☐ Death of a child **within the State scope** and **a resident** of this team's jurisdiction (**Entire form required by State**)
- ☐ Death of a child **outside the State scope** but **under 18 years of age** and **a resident** of this team's jurisdiction (**Only Section I required by State**)
- ☐ Death of a child **within the State scope** but **not a resident** of this team's jurisdiction (**No information required by State**)
- ☐ **Other** death of a child **not a resident** of this team's jurisdiction (**No information required by State**)
- ☐ **Other** (**No information required by State**)

I. DEATH CERTIFICATE INFORMATION *This information should come directly from the death certificate.*

| | | | | | | |
|---|---|---|--|--|---|---------------|
| 1. Local death certificate number | | 2. Death certificate year | | 3. County of death | | |
| | | | | | | |
| 4. First Name | | 5. Middle Name | | 6. Last Name | | |
| | | | | | | |
| 7. County of injury | | | 8. Sex | | | |
| <input type="checkbox"/> Not applicable | | | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown | | | |
| 9. Date of death | | | 10. Date of birth | | | |
| ___/___/___ | | | ___/___/___ | | | |
| 11. Age last birthday | | 12. Age if less than one year, more than 1 day | | 13. Age if under 1 day | | |
| ___ Years <input type="checkbox"/> Unknown | | ___ Months ___ Days <input type="checkbox"/> Unknown | | ___ Hours ___ Minutes <input type="checkbox"/> Unknown | | |
| 14. City or town of death | 15. Hour of death (24 hr clock) | | 16. Date of injury, if applicable | | 17. Hour of injury (24 hr clock) | |
| | ___ : ___ <input type="checkbox"/> Estimate | | ___/___/___ | | ___ : ___ <input type="checkbox"/> Estimate | |
| 18a. Immediate cause of death | | | | 18b. Interval between onset and death | | |
| | | | | # ___ Years | | # ___ Hours |
| | | | | # ___ Months | | # ___ Minutes |
| | | | | # ___ Days | | |
| 19a. Due to or as a consequence of | | | | 19b. Interval between onset and death | | |
| | | | | # ___ Years | | # ___ Hours |
| | | | | # ___ Months | | # ___ Minutes |
| | | | | # ___ Days | | |
| 20a. Due to or as a consequence of | | | | 20b. Interval between onset and death | | |
| | | | | # ___ Years | | # ___ Hours |
| | | | | # ___ Months | | # ___ Minutes |
| | | | | # ___ Days | | |
| 21a. Due to or as a consequence of | | | | 21b. Interval between onset and death | | |
| | | | | # ___ Years | | # ___ Hours |
| | | | | # ___ Months | | # ___ Minutes |
| | | | | # ___ Days | | |
| 22. Other significant conditions – conditions contributing to death but not resulting in the underlying cause given above | | | | | | |
| | | | | | | |
| 23. Autopsy conducted? | | 24. Case referred to ME/coroner? | | 25. Manner of death | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | <input type="checkbox"/> Natural <input type="checkbox"/> Undetermined <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Other _____ <input type="checkbox"/> Homicide | | |



CHILD DEATH REVIEW DATA COLLECTION FORM



The remainder of this form should be completed based on all records available for review of this death.

II. GENERAL INFORMATION

| | | | | | |
|--|------------------|--|---|--------------------------------------|--------------------|
| 1. Child's race (Check all that apply) | | | | | |
| <input type="checkbox"/> American Indian or Alaska Native | | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | | | |
| <input type="checkbox"/> Asian | | <input type="checkbox"/> White | | | |
| <input type="checkbox"/> Black or African-American | | <input type="checkbox"/> Unknown | | | |
| 2. Was the child of Hispanic or Latino origin? | | | 3. Did the child have a disability? | | |
| <input type="checkbox"/> Yes (Specify Cuban, Mexican, etc.) _____ | | | <input type="checkbox"/> Yes | | |
| <input type="checkbox"/> No | | | <input type="checkbox"/> Physical (specify) _____ | | |
| <input type="checkbox"/> Unknown | | | <input type="checkbox"/> Mental (specify) _____ | | |
| | | | <input type="checkbox"/> Sensory (specify) _____ | | |
| | | | <input type="checkbox"/> No | | |
| | | | <input type="checkbox"/> Unknown | | |
| 4. Street address of child's residence | 5. Apt. # | 6. City or town | 7. County | 8. State | 9. Zip Code |
| _____ | _____ | _____ | _____ | _____ | _____ |
| 10. Type of residence | | | | | |
| <input type="checkbox"/> Parental home | | <input type="checkbox"/> Relative's home (specify) _____ | | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Licensed group home | | <input type="checkbox"/> Child's own home | | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Licensed foster care | | <input type="checkbox"/> Homeless | | | |
| 11. Check all adults (18 or older) known to be living with the child at the time of death | | | | | |
| <input type="checkbox"/> Biological or adoptive parent # _____ | | <input type="checkbox"/> Relative _____ # _____ | | <input type="checkbox"/> None | |
| <input type="checkbox"/> Foster parent # _____ | | <input type="checkbox"/> Institutional staff # _____ | | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Step-parent # _____ | | <input type="checkbox"/> Other _____ # _____ | | | |
| <input type="checkbox"/> Parent's boyfriend/girlfriend # _____ | | <input type="checkbox"/> Other _____ # _____ | | | |
| <input type="checkbox"/> Relative _____ # _____ | | <input type="checkbox"/> Other _____ # _____ | | | |
| 12. Check all children (under 18 years of age) known to be living with the child at the time of death | | | | | |
| <input type="checkbox"/> Sister # _____ | | <input type="checkbox"/> Relative _____ # _____ | | <input type="checkbox"/> None | |
| <input type="checkbox"/> Brother # _____ | | <input type="checkbox"/> Relative _____ # _____ | | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Step-sister # _____ | | <input type="checkbox"/> Other _____ # _____ | | | |
| <input type="checkbox"/> Step-brother # _____ | | <input type="checkbox"/> Other _____ # _____ | | | |
| <input type="checkbox"/> Foster sister # _____ | | <input type="checkbox"/> Other _____ # _____ | | | |
| <input type="checkbox"/> Foster brother # _____ | | | | | |



CHILD DEATH REVIEW DATA COLLECTION FORM



II. GENERAL INFORMATION (continued)

| | | |
|--|--|--|
| 13. Relationship of child's primary caregiver to child | | |
| <input type="checkbox"/> Biological or adoptive mother | <input type="checkbox"/> Mother's boyfriend/girlfriend | <input type="checkbox"/> Institutional staff |
| <input type="checkbox"/> Biological or adoptive father | <input type="checkbox"/> Father's girlfriend/boyfriend | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sibling | <input type="checkbox"/> None |
| <input type="checkbox"/> Stepfather | <input type="checkbox"/> Other relative _____ | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Foster parent | <input type="checkbox"/> Friend | |
| 14. Age of primary caregiver | | |
| _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |

| | |
|---|--------------------------------------|
| 15. On what medical insurance was the child? (Check all that apply) | |
| <input type="checkbox"/> Private commercial insurance (including private HMO's and PPO's) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medicaid (including Healthy Options) | <input type="checkbox"/> None |
| <input type="checkbox"/> Basic Health Plan / Basic Health Plan Plus | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Children's Health Insurance Program (CHIP) | |

| | | |
|--|--|--|
| 16. Washington State Birth Certificate Number | 17. Paternal age at child's birth | 18. Maternal age at child's birth |
| _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | _____ Years <input type="checkbox"/> Unknown | _____ Years <input type="checkbox"/> Unknown |
| 19. Total number of children born to or adopted by mother | 20. Total number of children now dead born to or adopted by mother | |
| _____ # <input type="checkbox"/> Unknown | _____ # (Specify causes of other children's deaths in Section VIII) <input type="checkbox"/> Unknown | |

| | |
|--|--|
| 21. Was child a victim of intra-familial abuse or neglect? | 22. Were child's siblings victims of intra-familial abuse or neglect? |
| <input type="checkbox"/> Yes [If yes, specify type and relationship of perpetrator(s) to child] <input type="checkbox"/> Physical abuse _____ <input type="checkbox"/> Sexual abuse _____ <input type="checkbox"/> Emotional abuse _____ <input type="checkbox"/> Neglect _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes [If yes, specify type and relationship of perpetrator(s) to siblings] <input type="checkbox"/> Physical abuse _____ <input type="checkbox"/> Sexual abuse _____ <input type="checkbox"/> Emotional abuse _____ <input type="checkbox"/> Neglect _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |
| 23. Is there a history of domestic violence in the child's family? | |
| <input type="checkbox"/> Yes (specify relationship of victim to child) _____ (specify relationship of perpetrator to victim) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | |

| | |
|--|---|
| 24. Total number of referrals to CPS regarding child's family | 25. Total number of CPS investigations of child's family |
| _____ # <input type="checkbox"/> Unknown | _____ # <input type="checkbox"/> Unknown |
| 26. Were any siblings in licensed foster care or in a licensed group home at the time of the child's death? | |
| <input type="checkbox"/> Yes _____ # of siblings <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Not applicable | |



CHILD DEATH REVIEW DATA COLLECTION FORM



III. CIRCUMSTANCES OF DEATH

1. Check all circumstances that apply

- | | |
|--|---|
| <input type="checkbox"/> Fire (Complete Section III A) | <input type="checkbox"/> Drowning (Complete Section III F) |
| <input type="checkbox"/> Burn (Complete Section III B) | <input type="checkbox"/> Poisoning/Drug Intoxication (Complete Section III G) |
| <input type="checkbox"/> Fall (Complete Section III C) | <input type="checkbox"/> Vehicular Injury (Complete Section III H) |
| <input type="checkbox"/> Firearms (Complete Section III D) | <input type="checkbox"/> Other Circumstance (Explain in Section VIII) |
| <input type="checkbox"/> Sudden Infant Death Syndrome (Complete Section III E) | |

III A. Fire

1. Source of fire (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Matches | <input type="checkbox"/> Cooking appliance | <input type="checkbox"/> Furnace |
| <input type="checkbox"/> Lighter | Cooking appliance used as heating source? | <input type="checkbox"/> Fireplace |
| <input type="checkbox"/> Cigarette | <input type="checkbox"/> Yes | <input type="checkbox"/> Space heater |
| <input type="checkbox"/> Combustible liquid | <input type="checkbox"/> No | <input type="checkbox"/> Wood or pellet stove |
| <input type="checkbox"/> Explosives | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fireworks | <input type="checkbox"/> Electrical wire | <input type="checkbox"/> Unknown |

2. Was a smoke alarm present?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> No | <input type="checkbox"/> Not applicable |

3. If present, did smoke alarm function properly?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> No | <input type="checkbox"/> Not applicable |

4. If present, was smoke alarm located properly?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> No | <input type="checkbox"/> Not applicable |

5. Was a fire extinguisher present?

- | | | | |
|------------------------------|-----------------------------|----------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not applicable |
|------------------------------|-----------------------------|----------------------------------|---|

6. If present, did fire extinguisher function properly?

- | | | | |
|------------------------------|-----------------------------|----------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not applicable |
|------------------------------|-----------------------------|----------------------------------|---|

7. Did a fire escape plan exist for structure in which fire occurred?

- | | | | |
|------------------------------|-----------------------------|----------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not applicable |
|------------------------------|-----------------------------|----------------------------------|---|

8. Did the child know of the escape plan?

- | | | | |
|------------------------------|-----------------------------|----------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not applicable |
|------------------------------|-----------------------------|----------------------------------|---|

III B. Burn

1. Source of burn, other than fire

- | | |
|---|--|
| <input type="checkbox"/> Hot liquid (specify) _____ | <input type="checkbox"/> Appliance _____ |
| <input type="checkbox"/> Space heater | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical (specify) _____ | <input type="checkbox"/> Unknown |

III C. Fall

1. Fall was from or into

- | | | |
|--|--|---|
| <input type="checkbox"/> Open window, no screen | <input type="checkbox"/> Crib | <input type="checkbox"/> Same height (e.g., tripping) |
| <input type="checkbox"/> Open window, screened | <input type="checkbox"/> Stairs, steps, porch | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Furniture | <input type="checkbox"/> Opening in surface (e.g., well) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Natural elevation (e.g., tree, cliff) | | |

2. Was child in a baby walker?

- | |
|----------------------------------|
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> No |
| <input type="checkbox"/> Unknown |



CHILD DEATH REVIEW DATA COLLECTION FORM



III D. Firearms

| | | | |
|--|--|--|---|
| 1. Type of firearm <input type="checkbox"/> Handgun <input type="checkbox"/> Rifle/Shotgun <input type="checkbox"/> Military <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | | 2. Use of firearm at time of injury <input type="checkbox"/> Cleaning <input type="checkbox"/> Hunting <input type="checkbox"/> Loading <input type="checkbox"/> Playing <input type="checkbox"/> Target shooting <input type="checkbox"/> Demonstrating <input type="checkbox"/> Intent to harm <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | |
| 3. Was the gun locked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | 4. If locked, type of lock (Check all that apply) <input type="checkbox"/> Locked cabinet or box <input type="checkbox"/> Trigger lock <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | 5. Was key stored with lock? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |
| 6. Was ammunition stored with firearm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 7. Did person using firearm take organized safety training? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |

III E. Sudden Infant Death Syndrome

| | | |
|--|--|--|
| 1. Position of infant when last put down <input type="checkbox"/> On stomach, face down <input type="checkbox"/> On stomach, face to side <input type="checkbox"/> On stomach, face position unknown <input type="checkbox"/> On back <input type="checkbox"/> On side <input type="checkbox"/> Unknown | 2. Position of infant at discovery <input type="checkbox"/> On stomach, face down <input type="checkbox"/> On stomach, face to side <input type="checkbox"/> On stomach, face position unknown <input type="checkbox"/> On back <input type="checkbox"/> On side <input type="checkbox"/> Unknown | 3. Location of infant when found <input type="checkbox"/> Crib <input type="checkbox"/> Playpen <input type="checkbox"/> Conventional adult bed <input type="checkbox"/> Conventional child bed <input type="checkbox"/> Waterbed <input type="checkbox"/> Couch or chair <input type="checkbox"/> Floor <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown |
| 4. Firmness of sleeping location <input type="checkbox"/> Soft <input type="checkbox"/> Average or Firm <input type="checkbox"/> Unknown | 5. Was infant co-sleeping? <input type="checkbox"/> Yes If yes, with whom? <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 6. If infant was found in a location not designed for infant sleeping, was a crib or infant bed available at this time for this infant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| 7. Did the primary person supervising the infant have knowledge of proper infant sleep position? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| 8. Was infant healthy in last 2 weeks of life? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify illness) _____ <input type="checkbox"/> Unknown | 9. Was infant exposed to environmental smoke? <input type="checkbox"/> Yes (specify type/frequency) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | |

CHILD DEATH REVIEW DATA COLLECTION FORM

III F. Drowning

| | | | |
|---|--|--|--|
| 1. Place of drowning | | | |
| <input type="checkbox"/> Ocean | <input type="checkbox"/> Pond | <input type="checkbox"/> Hot tub/spa tub | <input type="checkbox"/> Cistern |
| <input type="checkbox"/> Sound | <input type="checkbox"/> Creek | <input type="checkbox"/> Swimming pool | <input type="checkbox"/> Septic Tank |
| <input type="checkbox"/> Lake | <input type="checkbox"/> Gravel pit | <input type="checkbox"/> Wading pool | <input type="checkbox"/> Bucket |
| <input type="checkbox"/> River | <input type="checkbox"/> Bath tub | <input type="checkbox"/> Well | <input type="checkbox"/> Drainage ditch |
| <input type="checkbox"/> Irrigation canal | | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Unknown | | | |
| 2. Child's activity at time of drowning | 3. Was the area gated? | 4. Was a lifeguard present? | 5. Was a warning sign posted? |
| <input type="checkbox"/> Boating <input type="checkbox"/> Swimming <input type="checkbox"/> Playing in the water <input type="checkbox"/> Playing near the water (beach, dock) <input type="checkbox"/> On a rubber raft or innertube <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes If yes, gate was <input type="checkbox"/> Locked <input type="checkbox"/> Unlocked <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | <input type="checkbox"/> Yes (specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |
| 6. Had child taken organized swimming lessons? | | 7. Could the child swim? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 8. Was the child wearing a floatation device? | | 9. If yes, was the floatation device Coast Guard approved? | |
| <input type="checkbox"/> Yes (specify) _____ <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Not applicable | | <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Not applicable | |

III G. Poisoning / Drug Intoxication

| | |
|--|--|
| 1. Type of poisoning / drug intoxication (Specify name of substance involved) | |
| <input type="checkbox"/> Over-the-counter medication _____ <input type="checkbox"/> Medication prescribed for child _____ <input type="checkbox"/> Medication prescribed for another _____ <input type="checkbox"/> Chemical _____ <input type="checkbox"/> Illegal drug _____ <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Carbon monoxide (CO) or other gas inhalation _____ <input type="checkbox"/> Food product _____ <input type="checkbox"/> Herbal remedy _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown |
| 2. Location where substance was stored | 3. Was substance in safety packaging? |
| <input type="checkbox"/> In closed, locked area <input type="checkbox"/> Other _____ <input type="checkbox"/> In closed, unlocked area <input type="checkbox"/> Unknown <input type="checkbox"/> In open area <input type="checkbox"/> Not applicable | <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain in Section VIII) <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |
| 4. If carbon monoxide poisoning, was a CO detector present? | 5. If CO detector was present, was it functioning properly? |
| <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Not applicable | <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No (Explain in Section VIII) <input type="checkbox"/> Not applicable |
| 6. Was poison control center called at time of poisoning/drug intoxication? | 7. If medication involved, was it dispensed correctly? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No (Explain in Section VIII) <input type="checkbox"/> Not applicable |



CHILD DEATH REVIEW DATA COLLECTION FORM



III H. Vehicular Injury

| | | | | | |
|--|--|--|--|--|--|
| 1. Vehicle in / on which child was occupant | | | 2. Vehicle that struck child or child's vehicle | | |
| <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Sport Utility <input type="checkbox"/> School bus <input type="checkbox"/> Other bus <input type="checkbox"/> RV | <input type="checkbox"/> Motorcycle <input type="checkbox"/> Truck <input type="checkbox"/> Riding mower <input type="checkbox"/> Farm tractor <input type="checkbox"/> Other farm vehicle <input type="checkbox"/> All terrain vehicle | <input type="checkbox"/> Semi/tractor trailer <input type="checkbox"/> Snowmobile <input type="checkbox"/> Boat <input type="checkbox"/> Bicycle <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Sport Utility <input type="checkbox"/> School bus <input type="checkbox"/> Other bus <input type="checkbox"/> RV | <input type="checkbox"/> Motorcycle <input type="checkbox"/> Truck <input type="checkbox"/> Riding mower <input type="checkbox"/> Farm tractor <input type="checkbox"/> Other farm vehicle <input type="checkbox"/> All terrain vehicle | <input type="checkbox"/> Semi/tractor trailer <input type="checkbox"/> Snowmobile <input type="checkbox"/> Boat <input type="checkbox"/> Bicycle <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |
| 3. Position of child | | 4. Location of injury (Check all that apply) | | | |
| <input type="checkbox"/> Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger - Front seat <input type="checkbox"/> Passenger - Back seat <input type="checkbox"/> Passenger - Middle seat <input type="checkbox"/> Passenger - Position Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | | <input type="checkbox"/> Sidewalk <input type="checkbox"/> Intersection <input type="checkbox"/> Shoulder <input type="checkbox"/> Off-road (e.g., dirt road, snow) <input type="checkbox"/> Driveway <input type="checkbox"/> Highway <input type="checkbox"/> City street <input type="checkbox"/> Rural road <input type="checkbox"/> Body of water <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | | | |
| 5. Contributing factors of vehicle injury (Check all that apply) | | | | | |
| <input type="checkbox"/> Adverse road conditions <input type="checkbox"/> Excess speed <input type="checkbox"/> Mechanical failure <input type="checkbox"/> Adverse weather conditions <input type="checkbox"/> Alcohol and/or drug intoxication (See Section IV, questions 11-13) <input type="checkbox"/> Driver error <input type="checkbox"/> Other _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown | | | | | |
| 6. Age of operator of child's vehicle | | | 7. Age of operator of vehicle that struck child or child's vehicle | | |
| _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| 8. Ages of passengers in child's vehicle (other than child) | | | 9. Ages of passengers in vehicle that struck child or child's vehicle | | |
| Passenger #1 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | Passenger #1 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| Passenger #2 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | Passenger #2 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| Passenger #3 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | Passenger #3 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| Passenger #4 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | Passenger #4 _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| 10. What restraints were present in child's vehicle? For those restraints present, check if they were used for the child | | | | | |
| <input type="checkbox"/> Infant seat present <input type="checkbox"/> Toddler seat present <input type="checkbox"/> Booster seat present <input type="checkbox"/> Seatbelt present <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | <input type="checkbox"/> Used <input type="checkbox"/> Used <input type="checkbox"/> Used <input type="checkbox"/> Used <input type="checkbox"/> Not used <input type="checkbox"/> Not used <input type="checkbox"/> Not used <input type="checkbox"/> Not used <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown | | | |
| 11. Were restraints used for the child used properly or improperly? (If any were used improperly, explain in Section VIII) | | | | | |
| <input type="checkbox"/> Infant seat <input type="checkbox"/> Toddler seat <input type="checkbox"/> Booster seat <input type="checkbox"/> Seatbelt <input type="checkbox"/> Not applicable | | <input type="checkbox"/> Used properly <input type="checkbox"/> Used properly <input type="checkbox"/> Used properly <input type="checkbox"/> Used properly <input type="checkbox"/> Used improperly <input type="checkbox"/> Used improperly <input type="checkbox"/> Used improperly <input type="checkbox"/> Used improperly <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown | | | |
| 12. Was the child sitting in a seat with an airbag? | | | 13. Was the child injured by a deploying airbag? | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |
| 14. Was the child wearing a safety helmet at the time of injury? | | | 15. Was the child's safety helmet found at the scene? | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | | |



CHILD DEATH REVIEW DATA COLLECTION FORM



IV. ADDITIONAL INFORMATION ON CIRCUMSTANCES SURROUNDING ALL DEATHS

| | | | |
|---|---|---|---|
| 1. Place of injury or onset for circumstances other than vehicular injury (Check all that apply) | | | |
| <input type="checkbox"/> Child's residence | <input type="checkbox"/> Place of work | <input type="checkbox"/> Licensed group home | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Relative's residence | <input type="checkbox"/> Sports/athletic area | <input type="checkbox"/> Licensed day care center | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Friend's residence | <input type="checkbox"/> School or city park | <input type="checkbox"/> Licensed day care home | |
| <input type="checkbox"/> Farm | <input type="checkbox"/> State or county park | <input type="checkbox"/> Unlicensed day care home | |
| <input type="checkbox"/> School | <input type="checkbox"/> Licensed foster home | <input type="checkbox"/> Other _____ | |

| | |
|--|--|
| 2. If death was due to an injury, was injury intentional or unintentional? | 3. Age of primary person inflicting injury |
| <input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | _____ Years <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |

| | | | |
|---|--|---|---|
| 4. Relationship to child of primary person inflicting injury | | | |
| <input type="checkbox"/> Self | <input type="checkbox"/> Foster parent | <input type="checkbox"/> Friend | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Biological or adoptive mother | <input type="checkbox"/> Mother's boyfriend/girlfriend | <input type="checkbox"/> Acquaintance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Biological or adoptive father | <input type="checkbox"/> Father's girlfriend/boyfriend | <input type="checkbox"/> Babysitter | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Licensed child care worker | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Stepfather | <input type="checkbox"/> Other relative _____ | <input type="checkbox"/> Institutional staff | |

| | | | |
|--|--|---|---|
| 5. Relationship to child of primary person supervising child at time of injury / onset of illness | | | |
| <input type="checkbox"/> Biological or adoptive mother | <input type="checkbox"/> Mother's boyfriend/girlfriend | <input type="checkbox"/> Acquaintance | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Biological or adoptive father | <input type="checkbox"/> Father's girlfriend/boyfriend | <input type="checkbox"/> Babysitter | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Licensed child care worker | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Stepfather | <input type="checkbox"/> Other relative _____ | <input type="checkbox"/> Institutional staff | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Foster parent | <input type="checkbox"/> Friend | | |

| | |
|---|---|
| 6. Age of primary person supervising child | 7. Primary person supervising child at time of injury/onset appeared to be (Check all that apply) |
| _____ Years | <input type="checkbox"/> Under the influence of alcohol <input type="checkbox"/> Otherwise impaired (specify) _____ |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Under the influence of drugs <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Mentally ill <input type="checkbox"/> Not applicable |
| | <input type="checkbox"/> Developmentally disabled |

| | | |
|---|---|---|
| 8. Was a toxicology screen conducted on child? If yes, specify type and results (Check all that apply) | | |
| <input type="checkbox"/> Yes | | |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Urine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Positive (explain in Section VIII) | <input type="checkbox"/> Positive (explain in Section VIII) | <input type="checkbox"/> Positive (explain in Section VIII) |
| <input type="checkbox"/> Negative | <input type="checkbox"/> Negative | <input type="checkbox"/> Negative |
| <input type="checkbox"/> Inconclusive | <input type="checkbox"/> Inconclusive | <input type="checkbox"/> Inconclusive |
| <input type="checkbox"/> Pending | <input type="checkbox"/> Pending | <input type="checkbox"/> Pending |
| <input type="checkbox"/> No | | |
| <input type="checkbox"/> Unknown | | |

| | | |
|---|-----------------------------|----------------------------------|
| 9. Were x-rays of child taken just prior to or after death? If yes, specify results. | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Evidence of abuse (explain in Section VIII) | | |
| <input type="checkbox"/> No evidence of abuse | | |
| <input type="checkbox"/> Unknown if evidence of abuse | | |



CHILD DEATH REVIEW DATA COLLECTION FORM



IV. ADDITIONAL INFORMATION ON CIRCUMSTANCES SURROUNDING ALL DEATHS (continued)

| | |
|--|--|
| 10. Was impairment due to drug or alcohol use involved in this death? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 11. If yes, type of substance(s) used (Check all that apply) | 12. If yes, person(s) impaired (Check all that apply) |
| <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug (specify) _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | <input type="checkbox"/> Child <input type="checkbox"/> Person supervising child at time of illness/injury <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Not applicable |
| 13. Was an alleged perpetrator identified in this death? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 14. Were charges filed against an alleged perpetrator in this death? | |
| <input type="checkbox"/> Yes (specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 15. Does the alleged perpetrator care for other children at this time? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Not applicable | |
| 16. Was alleged perpetrator living with child at time of child's death? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Not applicable | |
| 17. Alleged perpetrator's history (Check all that apply) | |
| <input type="checkbox"/> Abuse/neglect of other children <input type="checkbox"/> Mental illness <input type="checkbox"/> Violent behavior <input type="checkbox"/> Other criminal behavior (specify) _____ _____ <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Unknown _____ <input type="checkbox"/> Drug abuse <input type="checkbox"/> Not applicable | |
| 18. Had child ever attempted suicide? | |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. Had child recently spoken of suicidal thoughts? | |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 20. Had child ever experienced mental health problems? | |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 21. Had child ever received mental health services? | |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 22. Did child experience a life crisis just prior to death? | |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 23. Had a friend or relative of child committed suicide? | |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 24. Had child ever intentionally injured himself or herself? | 25. Had child ever engaged in behaviors that threatened his or her own life? |
| <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 26. Was child a runaway at time of death? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |



CHILD DEATH REVIEW DATA COLLECTION FORM



V. INFANT DEATHS Answer the following questions only for children less than one year old.

| | |
|---|--|
| 1. Gestational age at birth _____ Weeks <input type="checkbox"/> Unknown | 2. Birth weight _____ Grams <input type="checkbox"/> Unknown |
| 3. If gestational age and birth weight are unavailable, is there a notation of prematurity in the medical record? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | |
| 4. If multiple birth, number _____ # <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable | 5. Resuscitation at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 6. Child's Apgar scores at birth _____ 1 Minute Score <input type="checkbox"/> Unknown _____ 5 Minute Score <input type="checkbox"/> Unknown | 7. Did mother abuse drugs during pregnancy? <input type="checkbox"/> Yes (specify type) _____ (specify amount/frequency) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 8. Did mother use alcohol during pregnancy? <input type="checkbox"/> Yes (specify amount/frequency) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | 9. Did mother smoke during pregnancy? <input type="checkbox"/> Yes (specify amount/frequency) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 10. First prenatal visit which trimester? <input type="checkbox"/> First <input type="checkbox"/> Unknown <input type="checkbox"/> Second <input type="checkbox"/> Not applicable <input type="checkbox"/> Third | 11. Total number prenatal visits _____ # <input type="checkbox"/> Unknown |
| 12. Were there medical complications during pregnancy? <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown | 13. Did child experience neonatal complications? <input type="checkbox"/> Yes (Explain in Section VIII) <input type="checkbox"/> No <input type="checkbox"/> Unknown |



CHILD DEATH REVIEW DATA COLLECTION FORM



VI. RECORDS FOR REVIEW

| 1. Check which records were relevant for this review. | 2. Were these records available for this review? If no, explain in #4 | 3. Were there problems obtaining the records or with their content? If yes, explain in #5 |
|---|---|---|
| <input type="checkbox"/> Death certificate | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Birth certificate | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Early Notification of Childhood Deaths (ENCD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Death scene investigation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Medical Examiner/Coroner | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Medical records | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Emergency medical services | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Fire investigator | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Motor vehicle crash report | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Social services | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Public health records | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> CPS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> School records | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. If any requested records were not available for the review, please explain which records and why they were not available. | | |
| | | |
| | | |
| | | |
| 5. If there were difficulties with obtaining the records or with the records' content, please describe. Be specific about which records. | | |
| | | |
| | | |
| | | |
| 6. If issues of confidentiality prevented the exchange of information, please explain the issues. | | |
| | | |
| | | |
| | | |



CHILD DEATH REVIEW DATA COLLECTION FORM



VII. COMMITTEE CONCLUSIONS

| |
|---|
| 1. Was physical abuse a factor in this death? Please refer back to Section II, Questions 20-25 in making your determination. |
| <input type="checkbox"/> Yes If yes, specify (Check all that apply) <input type="checkbox"/> Isolated act or omission <input type="checkbox"/> Pattern of abuse of child <input type="checkbox"/> Pattern of abuse in family <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 1a. If yes, explain |
| |
| |
| |
| |
| |
| 2. Was neglect a factor in this death? Please refer back to Section II, Questions 20-25 in making your determination. |
| <input type="checkbox"/> Yes If yes, specify (Check all that apply) <input type="checkbox"/> Isolated act or omission <input type="checkbox"/> Pattern of neglect of child <input type="checkbox"/> Pattern of neglect in family <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 2a. If yes, explain |
| |
| |
| |
| |
| |
| |
| 3. Was delayed / inadequate medical attention by a caregiver a factor in this death? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 3a. If yes, explain |
| |
| |
| |
| |
| |



CHILD DEATH REVIEW DATA COLLECTION FORM



VII. COMMITTEE CONCLUSIONS (continued)

| |
|--|
| 4. Did panel members concur on the cause of death? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4a. If no, explain |
| |
| |
| |
| |
| |
| |
| 5. Did panel members concur on the manner of death? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5a. If no, explain |
| |
| |
| |
| |
| |
| |
| 6. If an autopsy was not conducted, might an autopsy have provided additional useful information, given all that is known at this time? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable |
| 6a. If yes, explain |
| |
| |
| |
| |
| |
| |
| 7. Were agency policy or practice issues raised as a result of this review? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7a. If yes, explain |
| |
| |
| |
| |



CHILD DEATH REVIEW DATA COLLECTION FORM



VII. COMMITTEE CONCLUSIONS (continued)

| |
|---|
| 8. Were system issues raised as result of this review? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8a. If yes, explain |
| |
| |
| |
| |
| |
| |
| 9. In the committee's estimation, was this death preventable? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine |
| 9a. Explain |
| |
| |
| |
| |
| |
| |
| 9b. If yes or unable to determine, please list all prevention strategies currently in place that address deaths of this kind |
| |
| |
| |
| |
| |
| |
| 9c. If yes or unable to determine, please list possible prevention strategies not currently in place that would address this type of death |
| |
| |
| |
| |
| |

[illegible]



CHILD DEATH REVIEW DATA COLLECTION FORM



IX. REVIEW INFORMATION

| | | |
|--|---|---|
| 1. Check all committee members who were present during any portion of this review. | | |
| <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Emergency Medical Services <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Medical Examiner/Coroner <input type="checkbox"/> Mental Health/Social Services <input type="checkbox"/> Pediatrician/Family Practice Physician <input type="checkbox"/> Prosecutor | <input type="checkbox"/> Local Health Jurisdiction <input type="checkbox"/> Faith Community <input type="checkbox"/> Fire Review/Prevention <input type="checkbox"/> Forensic Pathology <input type="checkbox"/> Military Organization <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Traffic Safety/State Patrol | <input type="checkbox"/> Trauma Care <input type="checkbox"/> Tribes <input type="checkbox"/> Schools <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ |
| 2. Is this a DSHS Children's Administration case? | | 3. If this is a DSHS Children's Administration case, which DSHS region? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 |
| 4. Child death review team reviewing death | | 5. Date review completed |
| | | ____/____/____ |
| 6. Person completing form | 7. Phone number | 8. Extension |
| | () - | |

Child Death Review

Data Collection Instructions



August 2005

Child Death Review Data Collection Instructions Table of Contents

| | |
|--|----|
| GENERAL INFORMATION | 2 |
| SECTION I. DEATH CERTIFICATE INFORMATION | 8 |
| SECTION II. GENERAL INFORMATION | 10 |
| SECTION III. CIRCUMSTANCES OF DEATH | 14 |
| SECTION IV. ADDITIONAL INFORMATION ON CIRCUMSTANCES | 17 |
| SECTION V. INFANT DEATHS (Deaths of children less than one year old) | 19 |
| SECTION VI. RECORDS FOR REVIEW | 19 |
| SECTION VII. COMMITTEE CONCLUSIONS | 20 |
| SECTION VIII. NARRATIVE | 22 |
| SECTION IX: REVIEW INFORMATION | 22 |

GENERAL DATA COLLECTION INFORMATION

Which deaths should the Child Death Review Teams review?

Unexpected deaths of children from birth through age 17 (until the 18th birthday) should be reviewed, except those unexpected deaths that are due to prematurity. However, if an unexpected death due to prematurity is defined as a Washington Department of Social and Health Services (DSHS) Children's Administration case, the case should be reviewed unless the Children's Administration Regional Administrator waives the requirement for a community review. A DSHS Children's Administration case is defined as one in which Children's Administration has provided services to a child or a child's family within the 12 months prior to the child's death. (This includes CPS referrals, even if the referral has been screened out.)

Child Death Review teams may determine that they wish to review additional deaths, e.g., all child deaths in their county or region, regardless of whether they fit within the State scope. However, for purposes of submitting information to the Washington State Department of Health, you need only provide complete review data on the deaths that fit within the scope defined above.

What are unexpected deaths?

Unexpected child deaths are those that do not result from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated (natural death) unless the illness or condition is the result of an injury, whether intentional or not.

Should we review deaths of children who were *residents* of our county or region, or child deaths that *occur* in our county or region?

For state purposes, each local health jurisdiction or regional review team should review deaths of children who were *residents* of the team's county or region at the time of death. If yours is the county of occurrence or death, please work with the county of residence to create the most comprehensive review possible. If you wish to review deaths other than those of residents of your jurisdictions, you may do so, but you will need to mark the appropriate case category at the top of the data collection form.

Screening deaths

The revised CDR Data Collection form allows teams to assure that all deaths of children who were residents of that team's jurisdiction are screened to determine if they should be reviewed. The revised form asks the teams to check the appropriate box in the first question, "Check case category." Teams will provide complete reviews for deaths of residents that fit within the State scope, and only death certificate information for the deaths of residents under 18 years of age that fall outside the State scope.

What information does the Child Death Review Team use to complete the form?

In Section I of the form, all information should come directly from the death certificate. However, for the remainder of the form, determinations should be made based on all available documentation regarding this child. The team will determine what information will be needed for a complete review and will attempt to obtain all relevant data. This body of information will be used to complete the form. The team should be cautious not to base answers on impressions about the child's circumstances. Mark "unknown" whenever information is not available to answer the question.

Whom should I contact for technical assistance?

You may contact Diane Pilkey or Beth Siemon at DOH if you need technical assistance.

Beth Siemon, CDR Program Coordinator
Telephone 360-236-3516
Fax 360-586-7868
E-mail beth.siemon@doh.wa.gov

Diane Pilkey, CDR Data and Assessment Coordinator
Telephone 360-236-3526
Fax 360-236-2323
E-mail Diane.Pilkey@doh.wa.gov

Web based application

Specific information and guidelines on gaining access to and using the CDR web application are available at: http://www.doh.wa.gov/cfh/CDR/cdr_tableofContents.htm

For Information on Generating Reports from the Web-Based CDR Application, See:
http://www.doh.wa.gov/cfh/CDR/cdr_mainmenu_report.htm#cdrmainmenureporting

For information on exporting your database for analysis, See:
http://www.doh.wa.gov/cfh/CDR/cdr_mainmenu_utilities_export.h

DATA COLLECTION FORM INSTRUCTIONS

FOR THE PAPER OR ELECTRONIC FORM

CASE CATEGORY

This item must be completed.

The revised form provides a list of case categories to track screening and to create flexibility for the team's ability to use the database for cases that fall outside the State scope. Please choose the appropriate category for the case being reviewed. The State requires only information from the first two categories, and only these two categories will be extracted from the database when using the extract function.

1. Death of a child *within the State scope* and *a resident* of this team's jurisdiction (Entire form required by State**).**

The State scope is defined as unexpected deaths of children from birth through age 17 (until the 18th birthday), except those unexpected deaths that are due to prematurity. However, if an unexpected death due to prematurity is defined as a Washington Department of Social and Health Services (DSHS) Children's Administration case, the case should be reviewed unless the Children's Administration Regional Administrator waives the requirement for a community review. A DSHS Children's Administration case is defined as one in which Children's Administration has provided services to a child or a child's family within the 12 months prior to the child's death. (This includes CPS referrals, even if the referral has been screened out.)

For the cases that fit within this category, the team must review the death and submit a completed data collection form to the State.

2. Death of a child *outside the State scope* but *under 18 years of age* and *a resident* of this team's jurisdiction (Only Section I required by State**).**

If the death falls outside the State scope as defined above, but the child was under 18 years of age and a resident of this team's jurisdiction, check this box. This allows the State to track that all child deaths during a given time period have been screened for review. The team may complete the entire form if they wish, but the team is only required to fill in the death certificate information.

3. Death of a child *within the State scope* but *not a resident* of this team's jurisdiction (No information required by State**).**

Check this category if this death is of a child that fits within the State scope but is not a resident of the team's jurisdiction. The team where the child was a resident is responsible for sending

review information to the State. This option allows the non-resident team to keep data in its database that does not get reported to the State. For example, a team may wish to review the death of a child who resided in another county because this death occurred in the team's county. Ideally, the two counties, the resident county and the county of occurrence, will work together, and the county of residence will submit the completed data collection form. However, the county of occurrence may want to keep these data in their database as well and would check this option in order to do so.

4. *Other* death of a child ***not a resident*** of this team's jurisdiction (No information required by State).

This allows the team to flag deaths of children that are outside the State scope and are not residents of the team's jurisdiction. For example, a team may wish to review the death of a child due to prematurity who resided in another county but died in the team's county. The State requires no information in this case, but the data will be available in the local team's database.

5. *Other* (No information required by State). This option allows for deaths other than those listed above. For example, a team may wish to use this database to review fetal deaths or deaths of residents through age 25. This option allows these data to be available to the local team.

SECTION I. DEATH CERTIFICATE INFORMATION

All the information in this section should come directly from the death certificate. If any of this information is missing from the death certificate, leave it blank.

ID Number: This is a unique identifier that is automatically created in the database by combining the local death certificate number, the death certificate year and the county of death. This number is created when once all three values are entered into the appropriate fields on the Death Certificate Information data entry page. If you need to correct any of these three data elements, you can do so any time before moving to Section II or hitting the “Save and Proceed” button. After moving to Section II or saving the record, you will need to contact the CDR database administrator so they can make the necessary changes.

1. Local death certificate number: Enter the *local* death certificate number found on the death certificate. This is a numeric field, so please omit any dashes. If you have a death certificate number that contains the year, separate the number and year into items 1 and 2.

2. Death certificate year: Enter the year assigned to the local death certificate. Most frequently, this will be the year the death certificate was issued. In rare circumstances, a previous year will be assigned because of the lag between death and discovery of a body.

3. County of death: Select the county in which the child died, not the county in which the child’s injury occurred or the child’s county of residence.

4 - 6. First, Middle and Last Names: Enter the name as found on the death certificate.

7. County of injury, if applicable: If the child died due to an injury, select the county in which the child’s injury occurred. Leave this item blank if not applicable or unknown.

8. Sex: Select the sex of the child. The “unknown” option is available for those teams that are choosing to review fetal deaths in which case it is possible that the sex is not known.

9. Date of death: Enter the date of death in the mmddyyyy format . For example, if the child died on February 23, 1999, enter “02231999.”

10. Date of Birth: Enter the date of birth in the mmddyyyy format, as above.

11. Age Last Birthday: Enter 0 if child is less than 1 year old.

12. Age is less than 1 year old, more than one day: Enter # months and # days.

13. Age if under one day: Enter # hours and # of minutes

14. City or Town of Death: Enter the city or town where death occurred, not the city/town in which the child's injury occurred or the child's city/town of residence.

15. Hour of death (24 hr clock): Enter the time of death in hour hour/minute minute format, using a 24-hour clock (00:00 to 23:59). For example, if a child dies at 10:30 a.m., enter "10:30." If a child dies at 2:34 p.m., enter "14:34." Note: If a child dies at midnight, "00:00" is the correct entry. If a child dies at one minute past midnight, i.e., 12:01 a.m., the correct entry is "00:01." There should be no entries with numbers greater than 23:59. Check the "estimate" button if the time provided is noted as an approximate time.

16. Date of injury, if applicable: If the child died due to an injury, enter the date in a mmddyyyy format. For example, if a child was injured on February 8, 1999, enter "02081999." Leave this item blank if not applicable or unknown.

17. Hour of injury (24 hr clock): Enter the hour the child was injured in the format described in #15. Leave this item blank if not applicable or unknown. Check the "estimate" button if the time provided is noted as an approximate time.

18a. through 21b. Cause of death: Enter the immediate cause and consequences of death, and the interval between onset and death. Enter the number in the first box and select the units (e.g., minutes, hours) in the second box. Enter this information directly from the death certificate.

25. Manner of death: Select which category of death is noted on the death certificate.

26. Specify Manner of Death: This must be filled in, if "Other" is chosen in #25.

The Child Death Review Team should complete the remainder of this form based on all information available for review of this child's death.

SECTION II. GENERAL INFORMATION

All items in this section must be completed. If you do not have information or the item is not applicable, choose "unknown" or "not applicable."

1. Child's race: Check all categories that apply. If someone is of Hispanic origin, this should be noted in #2, not under "Race." Choose from the following five racial categories:

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

2. Was the child of Hispanic or Latino origin? Hispanic or Latino origin is defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. If the child is of Hispanic or Latino origin, note culture or country of origin in the space provided, e.g., Cuban, Mexican, etc.

3. Did the child have a disability? Check if the child had a physical, mental or sensory disability, and specify the disability. The following categories are based on the *U.S. Department of Justice Civil Rights Division Title II Technical Assistance Manual of the Americans with Disabilities Act*.

Physical disability includes physiological disorders, cosmetic disfigurement or anatomical loss. Examples include cerebral palsy, epilepsy, cancer, HIV/AIDS, drug addition or alcoholism.

Mental disability includes psychiatric disability, retardation, learning disability and physical head trauma. For example, individuals may manifest or be diagnosed with depression, anxiety, paranoia, etc. Other mental disabilities include Down Syndrome,

effects of head injuries or disorders of the central nervous system that result in deficits in areas such as attention, reasoning, reading, calculations, and social competence.

Sensory disabilities include deafness and blindness.

4 – 11: These questions should be answered regarding the child’s primary residence at the time of death, not the place of the child’s injury or death. If this is unknown or if the child was homeless, leave these items blank.

4. Street address of child’s residence: The street address should include the house or building number, the street name, and the directional, e.g., NW, S, SE.

6. City or town: Enter the city or town of the child’s primary residence, not of the place of injury or death.

8. State: For most cases, Washington will be the state entered. However, in addition to residents of their jurisdiction, child death review teams may review deaths of children who were residents of other states at the time of death but who were injured or became ill in their jurisdiction. In any case, enter either the full name or the abbreviation of the state of residence. (Note: If the team is reviewing the death of a child who was a resident of another state, this information does not need to be submitted to DOH.)

10. Type of residence: Enter the type of child’s primary residence. “Licensed” refers to state-licensed facilities. An example of “homeless” may be living with a friend for a few weeks or staying in a shelter, in addition to living on the street.

11. Check all adults known to be living with the child at the time of death: Check the category of adult and enter the number of people in that category living with the child at the time of his or her death. “Adult” is defined as 18 years of age or older.

12. Check all children (under 18 years of age) known to be living with the child at the time of death: Check the category of child and enter the number of people in that category living with the child at the time of his or her death. “Child” is defined as under 18 years of age.

13. Relationship of child’s primary caregiver to child: Check the relationship of the child’s primary caretaker to the child at the time of the child’s death. The primary caretaker is defined as the person who is primarily responsible for ongoing emotional and financial support of the child. This should be distinguished from the person who was supervising the child at the time of injury/onset of illness or death.

14. Age of primary caregiver: Enter the age of the person selected in #13. Approximate if the exact age is unknown.

16. Washington State Birth Certificate Number: Enter the Washington State Birth Certificate number here. This is required for all reviews, not just for infant deaths. Enter the four-digit year at the beginning of the number, and do not include the letter. Mark “not applicable” if the child was born outside Washington State.

20. Total number of children now dead, born to or adopted by mother. This is the number of children either born to or adopted by the mother who have died, including this child's death. If this is the only child, please enter into explanation field ‘this child’.

21. Was child a victim of intra-familial abuse or neglect? If the child was a victim of abuse or neglect by a family member, check all applicable types of abuse or neglect and note the relationship(s) of the perpetrator to the child.

DSHS-proposed WACs (Washington Administrative Code) define “physical abuse” as follows:

The physical discipline of a child is not unlawful when it is reasonable and moderate and is inflicted by a parent, teacher or guardian for purposes of restraining or correcting the child.

The following actions are presumed unreasonable:

1. Throwing, kicking, burning, or cutting a child.
2. Striking child with a closed fist.
3. Shaking a child under age three.
4. Interfering with a child’s breathing.
5. Threatening a child with a deadly weapon.

Doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks.

DSHS-proposed WACs (Washington Administrative Code) define “neglect” as follows:

An act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child’s health, welfare, and safety. These acts may include but are not limited to:

- a) Failure to provide adequate food, shelter, clothing, supervision or health care. Poverty and/or homelessness in and of themselves do not constitute negligent treatment or maltreatment.

Actions or omissions resulting in injury to or creating a substantial risk to the physical and/or mental development of a child.

22. Were child’s siblings victims of intra-familial abuse or neglect? If any of the child’s siblings were victims of abuse or neglect by a family member, check all applicable types of

abuse or neglect and note the relationship(s) of the perpetrator to the child's sibling(s). See the definitions in Question 21.

23. Is there a history of domestic violence in child's family? If there was a history of domestic violence, note the relationship of the victim to the child, and the relationship of the perpetrator to the victim.

24. Total number of referrals to CPS regarding the child's family: Enter the number of times referrals were made to Washington State CPS regarding the child or the child's family. This should be distinguished from the number of *investigations* conducted by CPS regarding the child or the child's family. If the team has knowledge of CPS referrals in other states, this should be noted in the narrative.

25. Total number of CPS investigations of child's family: Enter the number of investigations conducted by Washington State CPS regarding the child or the child's family. This should be distinguished from the number of *referrals* to CPS regarding the child or the child's family. If the team has knowledge of CPS investigations in other states, this should be noted in the narrative.

SECTION III. CIRCUMSTANCES OF DEATH

For each relevant section, all items must be completed. If you do not have information or the question is not applicable, choose “unknown” or “not applicable.” Those sections that do not apply should be skipped. For example, in a boating injury involving a drowning, all items must be completed in the vehicular injury and drowning sections. All other sections should be skipped.

1. Check all categories of death that apply to this child’s death and then complete the applicable sections indicated in the menu on the left. There may be circumstances where more than one section is applicable, e.g., a boating accident that involved a drowning. In such a case, enter information in both the vehicular injury and drowning sections. If a specific category is not listed, e.g., shaken baby syndrome, strangulation, describe these circumstances in Section VIII Narrative, and fill out all other relevant information in the remaining sections.

III A. Fire

In collaboration with the State Fire Marshall, Child Death Review teams may request copies of the Fire Fatality Report Form from the Fire Protection Bureau of the Washington State Patrol. If you are reviewing the death of a child that occurred as a result of fire, contact Karen Jones at the Fire Protection Bureau to request this report.

1. Source of fire: Check only one source of fire. If a cooking appliance is used, check if the cooking appliance was used as a heating source.

3. If present, did smoke alarm function properly? Check if the smoke alarm functioned properly. If no smoke alarm was present, check “Not applicable.”

4. If present, was smoke alarm located properly? Check if the smoke alarm was located properly. If no smoke alarm was present, check “Not applicable.”

6. If present, did fire extinguisher function properly? Check if the fire extinguisher functioned properly. If there was no fire extinguisher, check “Not applicable.”

III B. Burn

1. Source of burn, other than fire: This section is to be used to capture deaths that occur because of burns other than those received in a fire, e.g., scalding, chemical burns.

III. D. Firearms

2. Use of firearm at time of injury: Choose the use of the firearm at the time of injury. In cases of suicide, mark “intent to harm.”

III E. Sudden Infant Death Syndrome: These questions should only be filled out for infants who have died from SIDS. If a child has died due to positional asphyxia and sleep position is relevant to the death, please use the questions below as a guide to providing narrative information in Section VIII. However, **do not** fill this section out for deaths due to positional asphyxia.

8. Was infant healthy in last two weeks of life? If you answer “Yes” to this question, be certain to note from what illness the child suffered within the last two weeks of life.

9. Was infant exposed to environmental smoke? If yes, specify the type of environmental smoke, e.g., cigarettes, wood burning stove, and also the frequency of the exposure, if known.

III F. Drowning

3. Was the area gated? For example, if it was a pool, was the pool area gated? If the drowning took place in a body of water that would not normally be gated or could not be gated, check “Not applicable,” e.g., ocean, sound.

4. Was a lifeguard present? This refers to certified lifeguards, not those who may be watching over the area informally.

5. Was a warning sign posted? Specify the warning sign present. Examples of warning signs include ocean signs warning of the dangerous tides or pool signs warning that no lifeguard is on duty.

III G. Poisoning/Drug Intoxication

1. Type of poisoning/drug intoxication: Be certain to note the type of substance that poisoned the child or that caused intoxication.

2. Location where substance stored: Check where the substance was stored. For example, if it was stored in a locked medicine cabinet, check “In closed, locked area.” If it was stored on the counter, check “In open area.” If poisoned by gas inhalation, mark “Not applicable.”

3. Was substance in safety packaging? If the substance was not in safety packaging, explain how it was stored.

7. If medication involved, was it dispensed correctly? Check if the medication was dispensed according to package or health professional instructions. If it was not dispensed correctly, explain how it was dispensed.

III H. Vehicular Injury: This section refers to all vehicles, not just motor vehicles, e.g., bicycles. Please note that we are able to obtain Washington State Patrol Collision Reports and fatality investigation information by contacting the Washington State Patrol Public Information Officer in your region. Please contact the Data and Assessment Coordinator for more information about the appropriate procedure.

3. Position of child: Check the position of the child. “Operator” is the driver of a motor vehicle. “Pedestrian” includes a bicyclist. If the child was a passenger, check whether the child was located in the front, middle or back seat of the vehicle.

4. Location of injury: Check all that apply. For example, if an injury took place in the intersection of a city street, check both “Intersection” and “City street.”

5. Contributing factors of vehicle injury: Check all contributing factors. Examples of adverse road conditions include rough roads, oil on the road, ice or snow or standing water on the road. Examples of mechanical failures include failed brakes and loss of steering. Examples of adverse weather conditions include rain, sleet, and fog. If alcohol or drug intoxication was a factor, be sure to fill out Section III, questions 10-12.

8. Age of passengers in child’s vehicle (other than child): Do not include the child whose death is being reviewed. If no passengers were present, check “Not applicable” for all passengers. If there were more than 4 passengers, note this in the narrative. This item is intended to address the issue of injury when minors are passengers in cars driven by minors.

9. Age of passengers in vehicle that struck child or child’s vehicle: If no passengers were present, check “Not applicable” for all passengers.

SECTION IV. ADDITIONAL INFORMATION ON CIRCUMSTANCES SURROUNDING ALL DEATHS

All items in this section must be completed. If you do not have information, or the item is not applicable, choose “unknown” or “not applicable.”

1. Place of injury or onset for circumstances other than vehicular injury: For vehicular injury, place of injury is included in Section II, Subsection A, question 4.

2. If death was due to an injury, was injury intentional or unintentional? Based on the information available, did the person inflicting the injury intend to inflict the injury? Intent in this case refers to intent to injure or harm the individual. In addition, if the person inflicting the injury intended to harm another, but injured the child instead, this would be categorized as an intentional injury.

3. Age of primary person inflicting injury: “Inflicted” refers to both unintentional and intentional injuries. The term “inflicted” does not determine guilt or a motive to harm but simply the act of one person harming another, whether intentionally or accidentally. A child who dies in a motor vehicle crash, for example, dies of an inflicted injury, even if the driver did not intend to harm the child. However, inadequate supervision does not constitute inflicting an injury. More than one person may have inflicted the injury. Select the primary person and note the age of this person.

5. Relationship to child of primary person supervising child at time of injury/onset of illness: This is the person who was actually supervising the child at the time of the injury or onset of illness, not necessarily at the time of death. Examples include a babysitter or brother. The term “inflicted” does not determine guilt or a motive to harm but simply the act of one person harming another, whether intentionally or accidentally.

8. Was a toxicology screen conducted of child? If a toxicology screen was conducted, select the type(s) and specify the results. If test results were positive, explain the results for each positive test.

9. Were x-rays of child taken just prior to or after death? If x-rays were taken, specify if they showed a history of abuse, and provide any details available.

13 – 17. Perpetrator: The term “perpetrator” does not refer to someone who has been deemed guilty or who has been identified in a crime, but refers to anyone who has injured another. For example, the driver of a car that causes the death of a child in another vehicle is a perpetrator, as is someone who accidentally shoots a child, regardless of the conditions surrounding the incident, and regardless of determinations of guilt. However, these questions do not apply in suicide deaths.

14. Were charges filed against an alleged perpetrator in this death? If charges were filed, specify the specific charges that were filed against the alleged perpetrator.

Questions 18 – 26 should be answered for all deaths, not just those in which suicide is suspected or where suicide has been listed as the manner of death on the death certificate. However, if this death is a suspected or confirmed suicide, please provide additional information in the narrative about issues surrounding the suicide.

18. Had child ever attempted suicide? If yes, state the circumstances, if any services were provided, and any suicide risk assessments made and by whom.

19. Had child recently spoken of suicidal thoughts? If yes, specify to whom, if known.

20. Had child ever experienced mental health problems? Some examples of mental health issues might include depression, eating disorders, and various forms of psychoses.

21. Had child ever received mental health services? If yes, please explain the services. In doing so, please include information regarding whether a suicide risk assessment had ever been conducted or determined to be needed; if suicidal ideation or behavior was recognized and any intervention implemented as a result; or if the child’s caregiver was made aware of these issues and provided support to address them.

22. Did child experience a life crisis just prior to death? When considering this question, consider the child’s perspective given the totality of the circumstances, i.e., what the child might have or would have considered a life crisis, not what an adult would have considered a life crisis. Please include any information about what kind of support, if any, the child was provided to deal with this life crisis.

23. Has a friend or relative of child committed suicide? If a friend or relative of the child has ever committed suicide, check “yes” and explain the relationship to the child and circumstances of the suicide.

24. Had child ever intentionally injured himself or herself? If yes, include the child’s age at the time of each injury and the circumstances of the injuries.

25. Had child ever engaged in behaviors that threatened his or her own life? If yes, include the child’s age at which the behaviors occurred and the circumstances of the behaviors.

SECTION V. INFANT DEATHS (Deaths of children less than one year old)

All items in this section must be completed if the team is reviewing the death of a child less than one year old. If you do not have information, or the item is not applicable, choose “unknown” or “not applicable.” For deaths of children one year or older, this section should be skipped.

3. If gestational age and birth weight are unavailable, is there a notation of prematurity in the medical record? If there is no ability to obtain gestational age and birth weight, check if there was a notation of prematurity in the medical record.

13. Did child experience neonatal complications? “Neonatal” is defined as less than 28 days old.

SECTION VI. RECORDS FOR REVIEW

1. Check which records were relevant for this review. Check all the records that the team determined were relevant to conducting a complete review of this child’s death.

2. Were these records available for this review? If no, explain in text box associated with type of record. Please detail why records were unavailable for the review.

3. Were there problems obtaining the records or with their content? If yes, explain in text box associated with type of record. Please detail any problems with obtaining record for the review or with the content of the records received.

SECTION VII. COMMITTEE CONCLUSIONS

All items in this section must be completed. If you do not have information, or the item is not applicable, choose “unknown” or “not applicable.”

Determinations by the Child Death Review team should be made after careful consideration of all available information regarding this child’s death.

In answering Questions 1 and 2, the team should refer back to Section II, questions 21 – 26. In addition, the committee should consider whether the physical abuse or neglect was a single act or omission, a pattern of abuse or neglect of the child, or a pattern of abuse or neglect in the family as a whole, involving more than just the child. The definitions below are designed to provide some guidance in making conclusions regarding abuse and neglect.

1. Was physical abuse a factor in this death?

DSHS-proposed WACs (Washington Administrative Code) define “physical abuse” as follows:

The physical discipline of a child is not unlawful when it is reasonable and moderate and is inflicted by a parent, teacher or guardian for purposes of restraining or correcting the child.

The following actions are presumed unreasonable:

6. Throwing, kicking, burning, or cutting a child.
7. Striking child with a closed fist.
8. Shaking a child under age three.
9. Interfering with a child’s breathing.
10. Threatening a child with a deadly weapon.

Doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks.

2. Was neglect a factor in this death?

DSHS-proposed WACs (Washington Administrative Code) define “neglect” as follows:

An act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child’s health, welfare, and safety. These acts may include but are not limited to:

- b) Failure to provide adequate food, shelter, clothing, supervision or health care. Poverty and/or homelessness in and of themselves do not constitute negligent treatment or maltreatment.
- c) Actions or omissions resulting in injury to or creating a substantial risk to the physical and/or mental development of a child.

7. Were agency policy or practice issues raised as a result of this review? These issues focus on those that are pertinent for a particular agency's policy or practice.

8. Were system issues raised as a result of this review? These issues focus on the ways in which various entities throughout the community interact with one another.

9. In the committee's estimation, was this death preventable? If a reasonable medical, educational, social, legal or psychological intervention could have prevented this death from occurring, the death is regarded as preventable. A "reasonable" intervention is one that would have been possible given the known conditions or circumstances and the resources available. Explain how this death was preventable, not preventable, or why the team was unable to determine preventability.

9a. Explain. Please briefly provide the basis for the committee's determination.

9b. If yes or unable to determine, please list all prevention strategies currently in place that address deaths of this kind. For example, if this child died of SIDS, you would list the Back to Sleep campaign if it you have one in the community in which the child lived.

9c. If yes or unable to determine, please list possible prevention strategies not currently in place that would address this type of death. Using a public health prevention perspective, please suggest strategies not yet in place that address deaths such as the one being reviewed.

SECTION VIII. NARRATIVE

This section must be completed.

It is critical that you provide a short description of the circumstances of the death of this child. Please use the perspective of someone who has not participated in the review in order to give some context in which to understand the questions in the remainder of the data form. Include a synopsis of the circumstances surrounding this child's death; any additional information requested in preceding questions; and any other information that will give a more complete picture of this child's death. If using the paper form, please write legibly.

SECTION IX. REVIEW INFORMATION

All items in this section must be completed.

1. Check all committee members who were present during any portion of this review.

Check each representative present at any part of this review. In order for a review to be considered complete, a core membership must be present at some time during each review. A core membership includes the following members: public health, Child Protective Services, Coroner/ME, health care professional, and law enforcement or prosecution.

2-3. Is this a DSHS Children's Administration case? If so, which DSHS region? A DSHS Children's Administration case is defined as one in which DSHS Children's Administration has provided services to a child or a child's family within the 12 months prior to the child's death. This includes CPS referrals, even those that have been screened out. The DSHS representative on your team should answer this question.